HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
DECEMBER 13, 2017
APPLICATION SUMMARY

NAME OF PROJECT:	Methodist Healthcare-Memphis Hospitals dba Methodist North Hospital
PROJECT NUMBER:	CN1709-029
ADDRESS:	3960 New Covington Pike Memphis (Shelby County), TN 38128
LEGAL OWNER:	Methodist Healthcare-Memphis Hospitals 1211 Union Avenue, Suite 865 Memphis (Shelby County), TN 38104
OPERATING ENTITY:	Not Applicable
CONTACT PERSON:	Carol Weidenhoffer (901) 516-0679
DATE FILED:	September 15, 2017
PROJECT COST:	$2,295,000
FINANCING:	Cash Reserves of Methodist Le Bonheur Healthcare
PURPOSE FOR FILING:	Relocation of thirty-four (34) licensed adult psychiatric beds

Methodist Healthcare-Memphis Hospitals operates five hospitals with 1,593 beds under a single license in Shelby County. It is seeking ***Consent Calendar*** approval to relocate 34 existing psychiatric beds from its main campus (Methodist University Hospital) located at 1265 Union Avenue to one of its four satellite campuses, Methodist North, which is located at 3960 New Covington Pike, also in Memphis. The project does not include the initiation of any other health service.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. **For relocation or replacement of an existing licensed health care institution:**

a. **The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative**

Methodist University Hospital is undergoing a modernization plan which was approved (CN1602-009A) at the May 25, 2016 Agency meeting for the construction and renovation of 470,000 SF of space located at 1211-1285 Union Avenue, Memphis (Shelby County), TN. It included the onsite replacement and modernization of the main campus including the construction of a new patient tower and adjacent building to consolidate ambulatory services. According to the applicant, an integral part of the project plan is the demolition of the Crews Building (where the psychiatric unit is currently located), which forces the physical relocation of the program and beds. With the approval and plans for the Methodist University Hospital campus, there is not a renovation option where the beds are housed in the Crew wing.

Methodist originally planned in the modernization plan application (CN1602-009A) to relocate the 34-bed psychiatric unit to the 12th and 13th floor in the Thomas building on the Methodist University campus. In the first supplemental response the applicant points out that the Thomas wing was originally built in 1966 and that older buildings on the Methodist University campus present challenges to the patient care experience. It was determined that the Thomas building was better suited for administrative offices and expansion of research space.

Methodist chose to relocate the beds to ones of its satellite campuses, 13.7 miles away which permits it to serve the same community with the same resources. Equipment, staff, and physicians will also be relocated. The location on the Methodist North campus is a better footprint for the psychiatric environment of care.

It appears that this criterion has been met.

b. **The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**

The bed occupancy for the 34 licensed bed adult psychiatric unit was 69% in 2014, 63% in 2015, and 59% in 2016. The applicant projects licensed of occupancy of 54% in Year 1 (2020) and 60% in Year 2 (2021) following completion of the project.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Methodist University Hospital is the core teaching hospital for the University of Tennessee Health Science Center. It is Methodist Le Bonheur Healthcare's tertiary academic medical center located in the center of the primary service area in downtown Memphis (Shelby), TN.

This project proposes to relocate the existing 34-bed inpatient psychiatric unit from Methodist University Hospital (Shelby County) to Methodist North Hospital (Shelby County) a distance of 13.7 miles. Methodist has operated the psychiatric unit since 1973. The project involves the renovation of almost 19,000 SF at the Methodist North campus which is 3,000 SF more space than the unit currently occupies. The proposed location is a separate building attached to the main hospital but contained as singular space with a separate entrance. The current location at Methodist North where the 34-bed psychiatric unit will be located currently houses medical-surgical beds. Those medical-surgical beds will be relocated to the fourth and fifth floors of the Methodist North Hospital which is currently configured for medical-surgical beds.

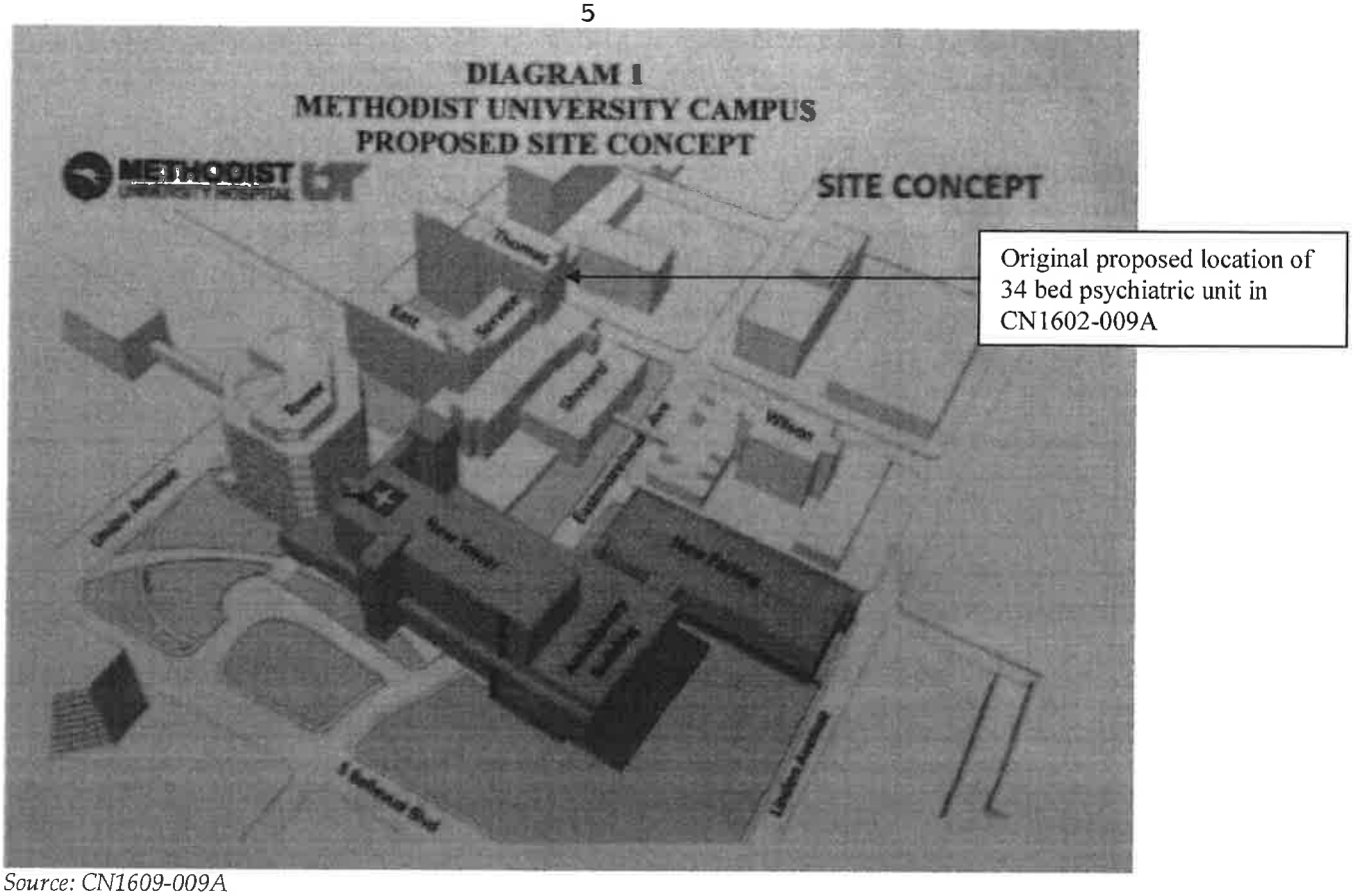
A detailed overview of the project is provided on pages 2R-3R of the application. If approved, the applicant expects to complete all construction and renovation and open by July 2019.

History

- **Methodist Healthcare - Memphis Hospitals, CN0111-089A** was approved at the February 27, 2002 Commission meeting for the relocation of inpatient psychiatric services that included fifty-eight (58) adult psychiatric beds located at Methodist Healthcare - Central Hospital, 165 Union Avenue, Memphis, TN to the second and third floors of the facility at 135 Pauline Street North, Memphis, TN. The applicant indicated the new location would support opportunities for collaboration among three providers of psychiatric services at 135 Pauline Street North. Methodist

Healthcare's relocated psychiatric beds on the second and third floor, Community Behavioral Health's psychiatric beds, approved at the September 2001 Commission meeting, on the fourth and fifth floor, and the University of Tennessee Department of Psychiatry on the sixth floor.

- **Methodist Healthcare - Memphis Hospitals, d/b/a Methodist University Hospital, CN0708-064A** was approved at the November 14, 2007 Agency meeting to relocate thirty-four (34) licensed adult psychiatric beds from 135 Pauline Street, Memphis, TN to 1265 Union Avenue, Memphis (Shelby County), TN 38104. The renovation of 14,616 square feet of space on Methodist University Hospital's main campus returned the applicant's adult psychiatric inpatient services to the same location as the applicant operated them before their move to 135 Pauline Street North in 2002 (as authorized under CN0111-089A). The return of the adult psychiatric services back 1.1 miles to the main campus was to afford the future psychiatric patients easier access to the specialized medical/surgical resources housed there.
- **Methodist Healthcare-Memphis Hospitals dba Methodist University Hospital CN1602-009A** was approved at the May 25, 2016 Agency meeting for the construction and renovation of 470,000 SF of space as part of a master plan to modernize Methodist University Hospital located at 1211-1285 Union Avenue, Memphis (Shelby County), TN. A component of the plan is the demolition of the Crews Building (where the 34 bed psychiatric unit is located) at the corner of Union Avenue and Bellevue Boulevard to improve circulation around the campus as well as increase the visibility of the main hospital entrance. In CN1602-009A the 34 bed psychiatric unit was planned to stay on the campus of Methodist University Hospital and be located in 22,000 SF of renovated space in the Thomas Building (please see Diagram I). However, after further analysis, it was determined the Methodist North campus was the optimal location, since the Thomas building was originally built in 1966 and older buildings on the Methodist University campus present challenges to the patient care experience. It was determined that the Thomas building was better suited for administrative offices and expansion of research space.



Source: CN1609-009A

In 1609-009A the 34 bed psychiatric unit was approved to move from the 8th floor of the Crews Building to the 12th and 13th floors of the Thomas Building as outlined in the following table.

Hospital Floor	Current Unit Type	Number of Beds (Licensed)		Hospital Floor	Proposed Unit Type	Number of Beds (Licensed)
Crews 8	Psych	34		Thomas Building 12	Psych	17
				Thomas Building 13	Psych	17
Total		**34**				**34**

Source: CN1609-009A

Ownership

- Methodist Healthcare-Memphis Hospitals (Methodist) is a not-for-profit corporation that operates five Shelby County hospitals under a single license with a combined total of 1,593 licensed beds.
- Methodist University Hospital is a wholly-owned subsidiary of a parent organization, Methodist Healthcare, which is a not-for-profit corporation with ownership and operating interests in healthcare facilities in West

Tennessee, North Mississippi and East Arkansas. Methodist LeBonheur Healthcare System is the ultimate parent organization.

Facility Information

The proposed project is a transfer of psychiatric beds within the Methodist Healthcare-Memphis Hospitals (Methodist) system in Shelby County. The project will add 34 licensed beds (10 private and 24 semi-private) to Methodist North Hospital increasing licensed beds from 246 to 280. Simultaneously, Methodist will close 34 licensed beds at Methodist University Hospital decreasing licensed beds from 617 to 583.

As mentioned above, Methodist University Hospital North (MUH-North) is a licensed 246 bed acute care hospital. The Joint Annual Report for 2016 indicates MUH-North staffed 220 beds of its licensed 246 beds, representing 56.1% licensed bed occupancy and 62.8% staffed bed occupancy.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).

Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.

Need

The applicant provides the following need justification in the application:

- Methodist University Hospital is undergoing a modernization program. The demolition of the Crews building (where the 34 bed psychiatric unit is located) will force the relocation of the program and beds.
- The proposed location provides more square footage for the service line adding more expansive group therapy and activities space, and a larger environment of care.
- The new location provides space isolated from the main building with a separate entrance making it an optimal setting for psychiatric services to ensure privacy and security.

Service Area Demographics

Shelby County is the primary service area of the proposed project. Highlights of the primary service are noted as follows:

- The total population of the Shelby County, Tennessee service area is estimated at 964,804 residents in calendar year (CY) 2017 increasing by approximately 2.1% to 985,379 in CY 2021.
- The overall statewide population is projected to grow by 4.2% also from 2017 to 2021.
- The Age 18+ population of Shelby County is estimated at 716,092 residents in calendar year (CY) 2017 increasing by approximately 1.8% to 728,710 in CY 2021. The Age 18+ population statewide is expected to grow 3.67% during this time period.
- The latest 2017 percentage of the Shelby County population enrolled in the TennCare program is approximately 29.2%. The statewide enrollment proportion is 22.6%.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics and Market Expert, Claritas Data.

Applicant Historical and Projected Utilization

Historical Utilization

As mentioned earlier, the applicant is requesting approval to relocate Methodist Healthcare-Memphis Hospitals' existing 34-bed inpatient adult psychiatric unit from Methodist University Hospital (Shelby County) to Methodist North Hospital (Shelby County) The following chart represents the historical utilization of Methodist University Hospital's current 34 bed inpatient adult psychiatric unit.

Methodist Healthcare-Memphis Hospital-
Historical Psychiatric Utilization-
34 beds

	Licensed Beds	Patient days			Occupancy			% Change
		2014	2015	2016	2014	2015	2016	
Methodist Healthcare-Memphis (Present Location)	34	8,467	7,791	7,336	68%	63%	59%	-13.4%

Source: CN1709-029

- The occupancy of the current Memphis-Healthcare Hospitals' 34 bed adult psychiatric unit averaged 63% during the reporting period 2014 to 2016.
- There was a 15.4% decline in patient days from 8,467 in 2014 to 7,336 in 2016.

Applicant Projected Utilization

The applicant's projected adult psychiatric unit inpatient utilization is presented in the following table.

Year	Beds	Patient Days	ADC	% Occupancy
Year 1 (2020)	34	6,640	18.2	54%
Year 2 (2021)	34	7,388	20.2	60%

Source: CN1709-029

Project Cost

Major costs are:

- Construction Cost plus Contingency- $1,605,875, or 70% of cost.
- Other Costs (technology, furniture, and escalation costs) - $274,125, or 11.9% of cost.
- Moveable Equipment: $250,000, or 10.1% of the total cost.
- For other details on Project Cost, see the Project Cost on page 29 in the original application.
- The renovation construction cost is $72.95 per square foot (/SF). As reflected in the table below, the renovated construction cost is below the 1st quartile of statewide hospital renovated construction projects from 2014 to 2016.

Statewide Hospital Construction Cost per Square Foot
2014-2016

	Renovated Construction	New Construction	Total Construction
1st Quartile	$160.66/sq. ft.	$260.18/sq. ft.	$208.97/sq. ft.
Median	$218.86/sq. ft.	$289.85/sq. ft.	$274.51/sq. ft.
3rd Quartile	$287.95/sq. ft.	$395.94/sq. ft.	$330.50/sq. ft.

Source: HSDA Applicant's Toolbox

Historical Data Chart

- According to the Historical Data Chart, Memphis University Hospital reported positive free cash flow in the following three previous years: $18,976,000 for 2014; $17,488,000 for 2015; and $17,158,000 for 2016.
- Deductions from gross operating revenue increased from $550,959,000 in 2014 to $595,710,000 in 2016.
- Memphis University Hospital reported charity care of $75,419,000 in 2014 decreasing to $72,099,000 in 2016.

Psychiatric Unit

- According to the Historical Data Chart, the 34 bed psychiatric unit reported the following Net Balance (Net Income – (Annual Principal Debt Repayment + Annual Capital Expenditures)) in the following three previous years: ($484,000) for 2014; $1,098,960 for 2015; and $1,206,000 for 2016.
- Deductions from gross operating revenue decreased -42% from $7,977,000 in 2014 to $5,615,000 in 2016.
- Charity care decreased from $710,000 in 2014 to $425,000 in 2016.

Projected Data Chart

Project only (34 adult psychiatric beds)

The applicant projects $10,735,000 in total gross revenue on 337 discharges during the first year of operation and $12,423,000 on 375 discharges in Year Two (approximately $33,128 per discharge). The Projected Data Chart reflects the following:

- Net operating income for the applicant is projected to be $700,000 in Year One increasing to $736,000 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $4,762,000 or approximately 38% of total gross revenue in Year Two.
- Charity care totals $580,000 in Year Two equaling 18 total patient discharges.

Total Hospital

The Projected Data Chart for the hospital reflects $908,825,000 in total gross revenue on 10,400 discharges during the first year of operation increasing by approximately 4.6% to $950,685,000 on 10,438 discharges in Year 2. The Projected Data Chart reflects the following:

- Net operating income is projected to be $5,082,000 in Year One decreasing to $4,213,000 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $177,798,000 or approximately 18.7% of total gross revenue in Year Two (2021).
- Charity care totals $88,980,000 in Year Two equaling 977 total patient discharges.

Charges

In Year One of the proposed project, the average charges are as follows:

- The proposed average gross charge per patient discharge is $33,127 in 2020.

- The average deduction is $20,430/discharge, producing an average net charge of $12,698/discharge.

Medicare/TennCare Payor Mix

- The expected payor mix for the Methodist North Hospital in Year 1 includes 96.6% ($10,367,781) for Medicare and 0.3% ($33,209) for TennCare/Medicaid, 0.2% ($20,529) for Commercial/Other Managed Care, and 2.9% ($312,992) for VA.

Note to Agency members-The applicant stated in the original application that severely and persistent mentally ill (SPMI) patients are psychiatrically disabled adults with Medicare Coverage. HSDA staff inquired about this circumstance since the majority of patients served was under Age 65. The applicant replied in the supplemental response that Medicare is available for certain people with disabilities who are under Age 65. SPMI is a mental health disability that is covered under Medicare.

The applicant was also asked why there was Charity Care of $490,000 projected in Year 1 and $580,000 in Year 2 in the psychiatric unit's Projected Data Chart, yet no charity care reported in the Payor Mix Chart. The applicant replied as follows: "The reported payor mix is determined based on gross patient revenue for the hospital and project. Patients are classified as Medicare, Medicaid/TennCare, Self-Pay, or Commercial/Other upon admission to the facility. Based on Methodist Le Bonheur Healthcare's contract structure or the patient's ability to pay, the amount that will be paid is calculated. The difference between gross patient revenue and the amount collected (or net patient revenue) is the deduction from revenue. In the Methodist system, a deduction is classified as a contractual adjustment, charity care write-off or bad debt. No patient is registered and admitted as a "charity payor". But rather if deemed appropriate per Methodist policy and collection procedures, a portion of the patient's account can be written-off as charity care. There is no charity gross patient revenue, and it would be inaccurate to show any charity in a payor mix table based on current policy and procedures."

- Methodist Healthcare contracts with all TennCare MCOs in the service area: United Healthcare Community Plan, AmeriGroup, BlueCare, and TennCare Select.

Financing

A September 12, 2017, letter from Chris McLean, Methodist Healthcare's Chief Administrative Officer, confirms that Methodist Le Bonheur Healthcare, the applicant's parent company, has sufficient cash reserves on hand at the corporate level to finance the proposed project.

Methodist Healthcare and Affiliates audited financial statements were provided with the application under the heading "Combined Balance Sheets". Review of the statements for the period ending December 31, 2016 reported cash and cash equivalents of $67,239,000, current assets of $1,316,052,000, total current liabilities of $210,758,000 and a current ratio (Current Assets/Current Liabilities) of 6.24 to 1.0.

Note: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant's Year One proposed direct patient care staffing includes the following:

Position	Existing FTEs	Projected Year 1
Activity Coordinator	0.6	0.5
Mental Health Counselor	1.0	1.0
Mental Health Technician	10.8	8.0
Patient Care Coordinator	1.1	1.0
Registered Nurse	11.2	10.0
Total Direct Care Positions	**24.7**	**20.5**

Source: CN0709-029

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- Methodist Healthcare-Memphis Hospitals is licensed by the Tennessee Department of Health.
- In supplemental #1, the applicant indicated in March 2016 a notice of 23-day termination proceedings related to inappropriate use of force by a security officer at Methodist North Hospital was received. The hospital's plan of correction was accepted by CMS, and a follow-up survey on April 5, 2016 determined the applicant was in full compliance with the Medicare Conditions of Participation.
- A copy of a CMS survey dated March 1, 2016 related to the above licensure action is located in Attachment D of Supplemental #1.
- A CMS letter of compliance dated April 8, 2016 (located in Attachment: C:Orderly Development D.2) indicates Methodist University Hospitals' plan of correction was accepted as a result of the follow-up survey ending on April 5, 2016 thereby restoring Medicare's Condition of Participation.

Certification

- The applicant is currently certified by Medicare and TennCare.

Accreditation

- Methodist has recently switched from Joint Commission to DNV accreditation. The applicant has maintained full accreditation for the last three years. The DNV accreditation process is an annual review and assessment process.
- The acronym DNV stands for Det Norske Veritas. According to the DNV website: "The requirements of the DNV GL - International Healthcare Accreditation are based upon those in our NIAHO standards that have been approved by the US Government's Centers for Medicare and Medicaid (GMS). The International requirements have been adapted so as to have applicability internationally, with sensitivity to local laws, practices and regulations, and have been accredited by ISQua. Our approach integrates proven quality and risk management principles with specific clinical and physical environment requirements".

Other Quality Standards

- In the first supplemental response the applicant commits to obtaining and/or maintaining the following:
  - Staffing levels comparable to the staffing chart presented in the CON application
  - Licenses in good standing
  - TennCare/Medicare certifications
  - Three years compliance with federal and state regulations
  - Has not been decertified in last three years
  - Self-assessment and external peer assessment processes
  - Data reporting, quality improvement, and outcome/process monitoring systems

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

- A complete listing of contractual and/or working relationships of the applicant is located on page 44 of the original application.

Impact on Existing Providers

- The applicant states the existing 34 psychiatric beds will be relocated within the same hospital system less than 14 miles away and will not negatively impact other providers in the service area.

Legal

- In Supplemental #2, the applicant indicates Methodist LeBonheur Healthcare (parent company of the applicant) is involved in one class

action lawsuit involving allegations of illegal billing practices. The lawsuit was originally filed in 2009 and dismissed without prejudice by a federal court in 2011. It was refiled in 2013 in Shelby County Chancery Court. It was removed to federal court in July 2017 and Methodist LeBonheur Healthcare has filed a Motion to Dismiss which is pending.

The applicant has submitted the required information on corporate documentation and legal interest in the site. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in **three** years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, pending or denied applications or outstanding Certificates of Need for this applicant.

Methodist Healthcare-Memphis Hospitals has financial interests in this project. Methodist Healthcare-Memphis Hospitals has no Letters of Intent, denied or pending applications.

Outstanding Certificates of Need

Methodist South Hospital, CN1503-008A, has an outstanding Certificate of Need that will expire August 1, 2018. The CON was approved at the June 24, 2015 Agency meeting for the following: (a) the construction of a 12,020 square foot (SF) building addition to the existing 9,902 SF main ED; (b) the construction of a 704 SF corridor that will connect the new addition to the existing non-acute fast track area located in the medical office building; and (c) the renovation of the existing main ED for an expanded total of approximately 22,626 square feet. The estimated project cost is **$8,741,870.00.** *Project Status: An Annual Progress Report dated July 13, 2017 stated all phases of construction are complete. The hospital is seeking final approval from the State of Tennessee. A final project report is pending.*

Methodist Healthcare-Memphis Hospitals d/b/a Methodist University Hospital, CN1602-009A has an outstanding project that will expire July 1, 2020. The CON was approved at the May 25, 2016 Agency meeting for the construction and renovation of approximately 470,000 square feet of space at Methodist University Hospital located at 1211-1265 Union Avenue in Memphis (Shelby County), TN 38104. The project involves the onsite replacement and modernization of the hospital campus including the construction of a new

patient tower and an adjacent building to consolidate ambulatory services. The project will not increase or decrease the hospital's existing 617 licensed beds. Of the 617 licensed beds, 204 beds will be relocated to the new patient tower and 28 medical-surgical beds will be converted for use as critical beds. As a part of the project, the hospital will add an interoperative, GE Discovery 3.0 Tesla MRI unit (iMRI), an Elekta Versa Linear Accelerator unit and will relocate existing PET, CT and infusion equipment and services. The estimated project cost is **$280,045,000.**
Project Status: A project status report received September 25, 2017 indicated the design for the project is 100% complete. The project is on schedule and within the proposed budget. The overall completion date for the entire project is December 2019.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for similar service area entities proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
(11/02/17)

LETTER OF INTENT

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general circulation in Shelby County, Tennessee, on or before September 8, 2017 for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Methodist Healthcare - Memphis Hospitals dba Methodist North Hospital (a general hospital), owned and managed by Methodist Healthcare - Memphis Hospitals (a not for profit corporation), intends to file an application for a Certificate of Need for the relocation of 34 licensed adult psychiatric beds. The beds are currently located at 1265 Union Avenue, Memphis, TN 38104 on the Methodist University Hospital campus. Methodist Healthcare – Memphis Hospitals proposes to move them to 3960 New Covington Pike, Memphis, TN 38128 on the Methodist North Hospital campus. Both hospitals are operated under the Methodist Healthcare - Memphis Hospitals license and total licensed beds for the System will not change. There will be renovation of 18,976 square feet of space to accommodate the relocated psychiatric beds and services. The project does not contain any major medical equipment or initiate or discontinue any health service; and it will not affect any other licensed bed complements. The estimated project cost is $2,295,000

The anticipated date of filing the application is on or before September 15, 2017. The contact person for this project is Carol Weidenhoffer, Senior Director of Planning and Business Development, who may be reached at: Methodist Le Bonheur Healthcare, 1211 Union Avenue, Suite 865, Memphis, TN, 38104, 901-516-0679.

Carol Weidenhoffer (Signature) | 9/7/17 (Date) | carol.weidenhoffer@mlh.org (E-mail Address)

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The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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HF51 (Revised 01/09/2013 – all forms prior to this date are obsolete)

Original Application
(COPY)

Methodist Healthcare Memphis Hospital d/b/a Methodist North Hospital

CN1709-029

Methodist Healthcare

September 14, 2017

Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Methodist Le Bonheur Healthcare, centered in Shelby County, is one of Tennessee's largest healthcare providers. Methodist Healthcare's principal acute care subsidiary organization is Methodist Healthcare--Memphis Hospitals that owns and operates five Shelby County hospitals. Methodist North Hospital is the 246-bed adult facility located in the northern quadrant of the Methodist service area. Methodist North is filing a Certificate of Need for the relocation of the 34-bed Methodist Psych inpatient unit currently located on the Methodist University Hospital campus to the Methodist North campus. As a result of extensive renovation and modernization plans approved by CN1602-009 for Methodist University, the building currently housing the Psych unit is scheduled to be demolished in 2019. Methodist North is the optimal location for the relocated service and beds.

Enclosed in triplicate is Certificate of Need Application, signed Affidavit, Proof of Publication as well as the check for the filing fee. Please let us know if you have any questions or need additional information.

Sincerely,

Carol Weidenhoffer

Carol Weidenhoffer
Senior Director of Planning and Business Development

cc: Byron Trauger

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. **Name of Facility, Agency, or Institution**

Methodist Healthcare-Memphis Hospitals dba Methodist North Hospital
Name

3960 New Covington Pike — Street or Route
Shelby — County

Memphis — City
TN — State
38128 — Zip Code

Website address: *www.methodisthealth.org/*

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. **Contact Person Available for Responses to Questions**

Carol Weidenhoffer — Name
Senior Director of Planning — Title

Methodist Le Bonheur Healthcare — Company Name
carol.weidenhoffer@mlh.org — Email address

1211 Union Ave, Suite 865 — Street or Route
Memphis — City
TN — State
38104 — Zip Code

Associate — Association with Owner
901-516-0679 — Phone Number
901-516-0621 — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

- **The project is to relocate Methodist Healthcare-Memphis Hospitals' existing 34-bed inpatient psychiatric unit from Methodist University Hospital (Shelby County) to Methodist North Hospital (Shelby County).**
- **Currently, Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. A vital part of that project plan is the demolition of the Crews building – where the psychiatric unit is housed - at the corner of Union Avenue and Bellevue Boulevard to improve circulation around the campus as well as increase the visibility of the main hospital entrance.**
- **This is a proposed transfer of psychiatric hospital beds within the Methodist Healthcare–Memphis Hospitals ("Methodist") system in Shelby County, with no net increase of beds in the county. Methodist has a single license for all five of its Shelby County hospitals; its total licensed acute care bed complement of 1,593 beds will not change.**
- **The project will add 34 licensed beds – 10 private and 24 semi-private - to Methodist North Hospital increasing licensed beds from 246 to 280. Simultaneously, Methodist will close 34 licensed beds at Methodist University Hospital decreasing licensed beds from 617 to 583.**
- **This project has been meticulously considered and planned. Consideration was given to keeping the 34-bed unit on the Methodist University Hospital campus as originally planned in CN1602-009. However after further analysis, it was determined the Methodist North campus was the optimal location.**
- **The project will renovate almost 19,000 square feet of space – which is 3,000 square feet more than the unit currently occupies - on the Methodist North campus. The proposed location is a separate building attached to the main hospital but contained as singular space with a separate entrance. The secured, controlled access makes it an improved setting for the Methodist psychiatric services to ensure privacy and security.**
- **The proposed location currently houses medical-surgical beds. This unit will be relocated to the fourth and fifth floors of the Methodist North hospital which is currently configured for medical-surgical beds.**

2) Ownership structure;

- **The applicant, owner, and licensee, Methodist Healthcare–Memphis Hospitals (Methodist), is a not-for-profit corporation that operates five Shelby County hospitals under a single license. The applicant is a wholly-owned subsidiary of a broader parent organization, Methodist Healthcare, which is a not-for-profit corporation with ownership and operating interests in healthcare facilities in West Tennessee, North Mississippi and East Arkansas.**

3) Service area;

- **Shelby County is the primary service area for this project.**
- **The largest city in Shelby County is Memphis, Tennessee which is the location**

of this project. The behavioral health service area for Methodist does not change with the relocation of the beds within the Memphis city limits.

4) Existing similar service providers;
   - **The service area contains other psychiatric inpatient facilities including Delta Medical Center, Crestwyn Behavioral Health Hospital, Lakeside Behavioral Health System, St. Francis Hospital – Park and Memphis Mental Health Institute (MMHI).**
   - **Four of the Shelby County facilities reported 590 licensed psychiatric beds between 2013 and 2015 with overall average occupancy of 67%, 64% and 71% respectively.**
   - **Crestwyn Behavioral Health Hospital opened in April 2015 transferring 60 beds from two existing Shelby County facilities (Delta 20 beds and St. Francis 40 beds) with no net bed increase in the service area. There is no Joint Annual report published yet for this facility and is therefore not included in reported market statistics.**

5) Project cost
   - **The estimated project cost is $2,295,000 which includes $1,384,375 in construction costs.**

6) Funding;
   - **The project will be funded in cash by the applicant's parent company, Methodist Le Bonheur Healthcare. Methodist is, and will remain, financially viable.**

7) Financial Feasibility including when the proposal will realize a positive financial margin; and
   - **The projections in this application show the Hospital and psychiatric inpatient service will remain financially viable with breakeven by year 1 (2020). Methodist North Hospital is an integral part of Methodist Healthcare-Memphis Hospitals currently with 246 of the total 1,593 licensed beds. This investment will contribute to the long term viability and sustainability of the campus.**

8) Staffing
   - **The applicant projects a total of 27.91 associated in the project's first full calendar year of operation. All current staff will be relocated along with the beds and service to the proposed location. FTEs are not added with this project.**

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;
   - **This application requests the relocation of Methodist's existing 34-bed psychiatric inpatient unit from Methodist University Hospital to Methodist**

North Hospital. Methodist has operated the psychiatric unit since 1973, and is committed to continue services. Currently, Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. The demolition of the Crews building – where the psychiatric unit is housed – will force the relocation of the program and beds.

- **The choice to relocate the 34 beds to a hospital within the same system, only 13.7 miles away, allows Methodist to serve the same community with the same resources. This project is needed in order to maintain accessibility to acute mental health services.**
- **The majority of patients admitted to the Methodist psychiatric unit are Severely and Persistently Mentally Ill (SPMI) patients who are psychiatrically disabled adults with Medicare coverage. Methodist will continue to serve chronic, SPMI patients in this unit with onsite acute medical services to treat comorbid medical conditions. Projections show the composition of the population and mix of populations served will change.**
- **Methodist currently plays an active role in the psychiatric continuum of care in the service area with positive relationships with referral sources. The majority of the applicant's patients arrive during crisis by ambulance or as direct referrals from the Crisis Assessment Center. This relocation maintains positive referral relationships in an improved location.**
- **The unit runs in a cost effective manner – the new location was most cost effective and least disruptive choice. The proposed location is attached to the main hospital but contained as singular space. The building is isolated from the rest of the general hospital with a separate entrance. The secured, controlled access makes it an optimal setting for psychiatric services to ensure privacy and security.**
- **The proposed location provides more square footage for the service line adding more expansive group therapy and activities space and a larger environment of care.**

2) Economic Feasibility;
   - **This project is economically feasible. The projections in this application show Methodist North Hospital and psychiatric inpatient service will remain financially viable with breakeven by year 1 (2020).**
   - **Methodist North Hospital is an integral part of Methodist Healthcare-Memphis Hospitals currently with 246 of the total 1,593 licensed beds. This investment will contribute to the long term viability and sustainability of the campus.**

3) Appropriate Quality Standards; and
   - **These beds will be accredited by the DNV. The psychiatric until will meet and exceed all relevant quality standards as regulated by DNV.**

4) Orderly Development to adequate and effective health care.
   - **This project has been meticulously considered and planned. Consideration was given to keeping the 34-bed unit on the Methodist University Hospital campus as originally planned in CN1602-009. However after further analysis, it was determined the Methodist North campus better met the needs of the program with improved space and environment of care.**
   - **The beds and programs are well established and a part of the service area's psychiatric continuum of care. The project will not negatively affect any providers in the service area. These are existing Methodist beds which will be relocated within the same hospital system less than 14 miles away.**
   - **Existing equipment, clinical leadership, professional staff, equipment and policies and procedures will be relocated with minimal disruption of services.**

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Please see Attachment A3-C for the Consent Calendar request.

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Methodist Healthcare – Memphis Hospitals		901-516-7000
Name		Phone Number
1211 Union Avenue, Suite 700		Shelby
Street or Route		County
Memphis	TN	38104
City	State	Zip Code

B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	F.	Government (State of TN or Political Subdivision)
B.	Partnership	G.	Joint Venture
C.	Limited Partnership	H.	Limited Liability Company
D.	Corporation (For Profit)	I.	Other (Specify)_____
E.	Corporation (Not-for-Profit) X		

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A-1.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.- This is an attachment (2) Org structure* **See Attachment A-4a-2**

5. Name of Management/Operating Entity (If Applicable)

Not Applicable		
Name		
Street or Route		County
City	State	Zip Code

Website address: _____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5.**

6A. Legal Interest in the Site of the Institution (Check One)

A. Ownership	X	D. Option to Lease	
B. Option to Purchase		E. Other (Specify) _____	
C. Lease of _____ Years			

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

Please see Attachment A-6A for the site control documents.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

   a. Size of site (***in acres***);

   b. Location of structure on the site;

   c. Location of the proposed construction/renovation; and

   d. Names of streets, roads or highway that cross or border the site.

   Please see Attachment 6B-1 for the plot plan.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

   Please see Attachment 6B-2 for the floor plan.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.
   The hospital is conveniently located on Covington Pike which is a major thoroughfare in north Memphis with intersections starting at I-40 and ending at I-269 making it easily accessible for patients traveling by car, public transportation (MATA bus) and ambulance. Covington Pike connects Memphis with communities across northeast Shelby County including Millington, Frayser, Raleigh, Bartlett and Arlington. A map of the MATA bus route is attached to show the bus stop next to the hospital. See Attachment 6B-3 for this map.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

7. **Type of Institution** (Check as appropriate--more than one response may apply)

A.	Hospital (Specify) Acute	X	H.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		I.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		J.	Rehabilitation Facility	
D.	Home Health Agency		K.	Residential Hospice	
E.	Hospice		L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
F.	Mental Health Hospital		M.	Other (Specify)_____	
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID				

Check appropriate lines(s).

8. **Purpose of Review** (Check appropriate lines(s) – more than one response may apply)

A.	New Institution		F.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	X
B.	Modifying an ASTC with limitation still required per CON				
C.	Addition of MRI Unit				
D.	Pediatric MRI				
E.	Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)_____		G.	Satellite Emergency Dept.	
			H.	Change of Location	X
			I.	Other (Specify)_____	
				_____	

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number *44-0049*

Medicaid Provider Number *44-0049*

Certification Type *Acute Care Facility*

Methodist Healthcare- Memphis Hospitals including Methodist North Hospital contract with above entities.

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No X N/A Medicaid/TennCare __Yes __No X N/A

10. **Bed Complement Data- Beds listed at North** 27

A. **Please indicate current and proposed distribution and certification of facility beds.**

	Current Licensed Beds	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	210	186				210
2) Surgical						
3) ICU/CCU	36	36				36
4) Obstetrical						
5) NICU						
6) Pediatric						
7)Adult Psychiatric			34			34
8) Geriatric Psychiatric						
9) Child / Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child / Adolescent Chemical Dependency						
13) Long Term Care Hospital						
14) Swing Beds						
15) Nursing Home - SNF (Medicare Only)						
16) Nursing Home - NF (Medicaid Only)						
17) Nursing Home - SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home- Licensed (Non-certified)						
19) ICF/IID						
20) Residential Hospice						
Total	246	222	34			280
*Beds approved but not yet in service						
**Beds Exempted under 10% per 3 year provision						

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

- **Currently, Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. A vital part of that project plan is the demolition of the Crews building – where the psychiatric unit is housed - at the corner of Union Avenue and Bellevue Boulevard to improve circulation around the campus as well as increase the visibility of the main hospital entrance.**
- **This is a proposed transfer of psychiatric hospital beds within the Methodist Healthcare-Memphis Hospitals ("Methodist") system in Shelby County, with no net increase of beds in the county. Methodist has a single license for all five of its Shelby County hospitals; its total licensed acute care bed complement of 1,593 beds will not change.**

- **The project will add 34 licensed beds to Methodist North Hospital increasing licensed beds from 246 to 280. Simultaneously, Methodist will close 34 licensed beds at Methodist University Hospital decreasing licensed beds from 617 to 583.**

Facility	Med-Surg	Psych	NICU	Total
Methodist University				
Current Complement	583	34	-	617
Proposed Change	-	<34>	-	<34>
Proposed Complement	583	-	-	583
Methodist North				
Current Complement	246	-	-	246
Proposed Change	-	+34	-	+34
Proposed Complement	246	34	-	280
Methodist South	150	-	6	156
Methodist Germantown*	295	-	24	319
Le Bonheur Children's*	195	-	60	255
Methodist Healthcare – Memphis Hospitals	1,459	34	90	1,593
*Note: Methodist Germantown recently opened 10 new med/surg beds approved and implemented beds under the new 10% bed regulations.				

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

Not Applicable. The applicant does not have outstanding CONs that have a licensed bed change component.

CON Number (s)	CON Expiration Date	Total Licensed Beds Approved

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: **Not applicable.**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Administration Offices					1,064	-	1,064
Biomed					647	-	647
Classroom					878	-	878
Behavioral Health Unit					16,387	-	16,387
Unit/Department GSF Sub-Total					18,976	-	18,976
Other GSF Total					-	-	-
Total GSF					18,976	-	18,976
*Total Cost					$1,384,375	-	$1,384,375
**Cost Per Square Foot					$72.95	-	$72.95
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					☒ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☒ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator

Not applicable. This project does not involve major medical equipment

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or:

2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____ Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____ Total Cost*: _____ ☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____	
☐ MRI	Tesla: ____ Magnet: ☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____ Total Cost*: _____ ☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____	
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI Total Cost*: _____ ☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____	

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (Sunday through Saturday)	Hours of Operation (example: 8 am – 3 pm)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

SECTION B: NEED

A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Psychiatric Inpatient Criteria and Standards

1. **Determination of need:** The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the program is adolescents, the age group if 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general populations. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that support exceeding the guideline of 30 beds per 100,000 general populations. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

   Not applicable, the applicant is not requesting new beds. Methodist proposes to relocate 34 existing psychiatric beds within the same hospital system, only 13.7 miles away. The psychiatric services will continue to serve the same community with the same resources. Methodist is committed to maintaining its high quality, cost efficient psychiatric unit with improved location and continued accessibility to established mental health services.

The bed need calculation for the primary service area, Shelby County, does not show a need for new beds for the adult and geriatric populations.

Current (2016) and Projected Year 1 (2020) Bed Need							
	Licensed Beds 2015	Current Population 2016	Projected Population 2020	Current Bed Need (30 beds / 100,000)	Projected Bed Need (30 beds / 100,000)	Current Net Bed Need (Surplus)	Net Bed Need (Surplus)
Ages 18-64		583,558	593,476	175.1	178.0		
Ages 65+		117,101	566,550	35.1	40.6		
Total	530	700,659	728,710	210.2	218.6	(319.8)	(311.4)
Population Source: Projected Population http://www.tn.gov/health/article/statistics-population and report from License Beds: Includes adult and geriatric licensed beds TN Joint Annual Reports: Methodist 34, MMHI 55, Delta 109, St. Francis-Park 67 and Lakeside 265; Excludes adolescent beds							

2. **Additional Factors:** An applicant shall address the following factors.

Currently, Methodist University operates 34 beds. Methodist is not proposing to add beds in the service area, but instead simply relocate an established service.

a. The willingness of the applicant to accept emergency involuntary and non-emergency indefinite admissions;
Methodist will continue to accept emergency involuntary and non-emergency indefinite admissions.

b. The extent to which the applicant serves or proposes to server the TennCare population and the indigent population;
Methodist will continue to serve the indigent population and the TennCare population on a case by case basis. The majority of patients admitted to the Methodist psychiatric unit are Severely and Persistently Mentally Ill (SPMI) patients who are psychiatrically disabled adults with Medicare coverage.

c. The number of beds designated as "specialty" beds (including united established to treat patient with specific diagnosis);
Methodist will continue to provide psychiatric services for SPMI patients who are psychiatrically disabled with Medicare coverage.

d. The ability of the applicant to provide continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;
Methodist will continue to provide a continuum of care such as outpatient, intensive outpatient treatment, and partial hospitalization through Methodist services or through referrals to an established network of providers.

e. Psychiatric units for patient with intellectual disabilities;
Intellectual disability is one of Methodist's exclusionary admission criteria. Methodist will continue to serve the chronic, SPMI patients.

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities.
Methodist is not a free standing facility. Methodist North is an acute care provider, and Methodist will continue to treat comorbid medical conditions for their psychiatric patients within the unit at Methodist North and/or within the Methodist Healthcare-Memphis Hospitals system. Transfer agreements are in place with all Methodist hospitals.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and
Methodist will continue to provide inpatient psychiatric services to all adult populations.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.
Methodist will continue treatment programs and staffing patterns that align with the treatment needs and expected lengths of stay. The applicant maintains flexible staffing dependent upon volume of admissions.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.
Methodist is not contracted by the TDMHSAS to provide such services.

j. Special consideration shall be given to a service that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.
Alliance Healthcare Services provides a crisis stabilization unit in the Shelby County service area.

3. **Incidence and Prevalence:** The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.
According to the TDMHSAS, Shelby County (Region 7) is the second highest region in the State of Tennessee for psychiatric admissions to a TDMHSAS funded substance abuse treatment center. Shelby County accounts for over 15%, or over 2,000 admissions annually, from 2013 to 2015 of total Tennessee admissions.

Table 10. Admissions by region

TDMHSAS Planning and Policy Region	Tennessee	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	N/A
FY13	13,765	1,783	2,911	1,690	1,457	1,909	1,617	2,351	47
	100%	12.95%	21.15%	12.28%	10.58%	13.87%	11.75%	17.08%	0.34%
FY14	13,918	1,895	2,804	1,815	1,589	1,866	1,778	2,165	6
	100%	13.62%	20.15%	13.04%	11.42%	13.41%	12.77%	15.56%	0.04%
FY15	13,702	2,036	2,542	1,817	1,831	1,681	1,712	2,075	8
	100%	14.86%	18.55%	13.26%	13.36%	12.27%	12.49%	15.14%	0.06%

Top 25% Bottom 25%

*Shelby County is represented by region 7 (TDMHSAS)

4. **Planning Horizon:** The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

The applicant proposes to continue established services and the operation of 34 adult psychiatric beds as shown in the first two years of operation in the newly proposed relocation.

Methodist Psychiatric Unit – Historical and Projected Utilization/Occupancy					
	2014	2015	2016	2020	2021
Discharges	441	388	370	337	375
Days	8,467	7,791	7,336	6,640	7,388
Average Daily Census	23.20	21.35	20.04	18.19	20.24
Occupancy Rate	68%	63%	59%	54%	60%

5. **Establishment of Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

Not applicable. Methodist is relocating existing services with an established service area.

Currently, Shelby County is the primary service area for the Methodist psychiatric inpatient services. The relocation of the inpatient unit from Methodist University to Methodist North will not impact the service area. Methodist will continue to serve the Shelby County community as we have for over 40 years. Over 85% of inpatient admissions originate from Shelby County. The proposed location is conveniently located on Covington Pike, a major thoroughfare in Shelby County, and it is easily accessible to patients traveling by car, public transportation or ambulance.

	Historical Utilization- County Residents	% of total procedures
Shelby County	313	85%
Other TN Counties	24	6%
Other AR Counties	14	4%
Other MS Counties	11	3%
Other States	9	2%
Total	370	100%

6. **Composition of Services:** Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

   The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

   The composition of services will not change. Methodist proposes to relocate existing psychiatric beds, services and resources to the Methodist North Hospital campus.

   The majority of patients admitted to the Methodist psychiatric unit are Severely and Persistently Mentally Ill (SPMI) patients who are psychiatrically disabled adults with Medicare coverage. Methodist will continue to serve chronic, SPMI patients in this unit with onsite acute medical services to treat comorbid medical conditions. Projections show the composition of the population and mix of populations served will change.

7. **Patient Age Categorization:** Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

   Methodist currently serves the 18+ age demographic and is committed to continue serving this age demographic in the new location at Methodist North's campus. The majority of the patients admitted to the inpatient unit have Medicare coverage due to psychiatric disabilities. Over 95% of current admissions to the psychiatric unit at Methodist are Medicare patients, yet less than 15% of patients admitted to Methodist are 65 years old or older. Treatment programs are well established in the 40+ year old

program to stabilize the chronically ill patient base that present with exacerbated symptoms due to non-compliance with outpatient treatment plans.

8. **Service to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

   The Methodist psychiatric unit currently serves the involuntarily committed, uninsured, or low-income and will continue to do so after the proposed relocation.

9. **Relationship to Existing Applicable Plans; Underserves Area and Populations:** The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

   There will be little to no impact on existing plans. These beds are already in existence, and will simply be moved from Methodist University Hospital to Methodist North Hospital so that these services can be continued throughout the Shelby County service area. Methodist serves the adult SPMI patient population which is a large Medicare psychiatrically disabled population. The patients that Methodist serves also tend to be noncompliant and are admitted on both a voluntary and non-voluntary basis. The applicant also cares for chronic and acute patients with comorbid medical condition that require a longer time to stabilize.

   The applicant treats TennCare patients on a case by case basis, and will continue to meet the medical and psychiatric needs of the TennCare population.

   Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

   Methodist is proposing to relocate established services with the same resources, composition of services and mix of populations. There is no projected or intended impact to other existing providers. The relocation is driven by modernization plans at the Methodist University Hospital campus.

   The service area contains other adult psychiatric inpatient facilities including Memphis Mental Health Institute (MMHI), Delta Medical Center, St. Francis Hospital – Park and Lakeside Behavioral Health System as well as a new facility in east Shelby, Crestwyn Behavioral Health Hospital.

Crestwyn Behavioral Health Hospital opened in April 2015 transferring 60 beds from two existing Shelby County facilities (Delta 20 beds and St. Francis 40 beds) with no net bed increase in the service area. There is no Joint Annual report published yet for this facility and is therefore not included in reported market statistics.

Four of the Shelby County facilities reported 590 licensed psychiatric beds between 2013 and 2015 with overall average occupancy of 67%, 64% and 71% respectively.

		Discharges			Days			Occupancy %		
Facility	Licensed Beds	2013	2014	2015	2013	2014	2015	2013	2014	2015
MMHI	55	1,213	1,565	1,547	18,207	16,877	17,299	90.7%	84.1%	86.2%
Delta **	109	2,116	2,873	2,875	30,897	37,501	36,741	77.7%	94.3%	92.3%
St Francis	102	1,875	1,384	1,502	15,847	11,502	13,825	42.6%	30.9%	37.1%
Lakeside	290	6,941	6,275	7,887	71,143	62,426	77,092	67.2%	59.0%	72.8%
Total	**590**	**12,670**	**12,538**	**14,199**	**145,240**	**136,773**	**152,748**	**67.4%**	**63.5%**	**70.9%**

Source: Joint Annual Reports 2013-2015 yet Lakeside did not report 2015 Schedule H therefore Schedule G utilization for MDC 19 used as estimate

10. **Expansion of Established Facility:** Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Not applicable. This project does not expand services or add beds.

11. **Licensure and Quality Considerations:** Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

The applicant is in compliance with the appropriate rules of the TDH and/or the TDMHSAS. Further licensure documentation is attached. The applicant proposes a dedicated men's and women's wing to ensure appropriate accommodations by gender. The applicant does not discriminate against different cultures or populations of people. The applicant maintains that they have a multi-diverse staff that aligns with the community.

12. **Institution for Mental Disease Classification:** It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

    Not applicable as Methodist is not an Institution for Mental Disease, but will serve TennCare patients on a case by case basis for those that present to the Methodist unit in need of medical attention.

13. **Continuum of Care:** Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

    The relocated psychiatric unit will be on the Methodist North Hospital campus which provides treatment acute medical care for any physical disorder in need of immediate medical attention prior to admission to the psychiatric unit or during the stay. The admitting facility will be able to appropriately provide any medical care needed.

    Through Methodist's expansive referral network, the continuum of care for these patients will provide the most conducive environment for these patients to thrive. Methodist currently plays an active role in the psychiatric continuum of care in the service area and has positive relationships with referral sources. Most of the applicant's patients arrive during crisis by ambulance and approximately 50% of admissions are direct referrals from the Crisis Assessment Center. The other half of the patients generally come through other Methodist Emergency Departments or are direct referrals from physician clinics. If the relocation is approved, Methodist's referral sources will re-direct ambulances and patients to the Methodist North campus with planned minimal disruption to the admission process.

14. **Data Usage:** The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

    The TDH and the TDMHSAS data are the data sources utilized.

15. **Adequate Staffing:** An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project. However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Methodist plans on relocating all staff with these beds and services to the proposed location. The project includes a total of 27.91 employees in the project's first full calendar year of operation. The clinical / direct patient care staff for this project are currently employed by Methodist with the staffing patterns as noted below. There will be no changes to staffing patterns with this project. Methodist utilizes flexible staffing model based on the psychiatric unit's census as shown below with 12-hour RN shifts.

Number of Physicians			
Specialty	Full Time	Part Time	Consulting
Psychiatry	2	2	
Neurology			1
Internal Medicine	1		

Number of Nursing Personnel			
Shift	RN	Aides	Other
Day	5 (12 hour shift)	2	4
Evening	1	4	
Night	3 (12 hour shift)	1	

RN Duty Roster			
Shift	SUN	MON - FRI	SAT
Day (12 hour shift)	3	5	3
Evening		1	
Night (12 hour shift)	3	3	3

16. **Community Linkage Plan:** The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for

psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

The applicant is not adding services and will continue working agreements and relationships that are already present.

17. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

The applicant has the ability and the willingness to serve equally all patients related to this application. Methodist is committed to continue to serve the patient population as they have for over 40 years.

18. **Quality Control and Monitoring:** The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

The applicant provides a quality improvement program that includes outcomes and process monitoring systems and currently reports all quality metrics to DNV. The applicant is engaged in reporting this data on an ongoing and regular basis.

19. **Data Requirements:** Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

The applicant agrees to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested.

B. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Methodist has been operating the psychiatric inpatient unit for 44 years and is committed to continue to operate the 34-bed unit in Memphis, Tennessee to provide high quality, cost effective services to the greater Shelby County service area. Methodist Healthcare – Memphis Hospitals is the only hospital system in the county that maintains hospital locations in all four quadrants of the county. The applicant plans to continue to invest in

Shelby County from all angles so that every community member has access to the full continuum of healthcare services they need.

C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable.

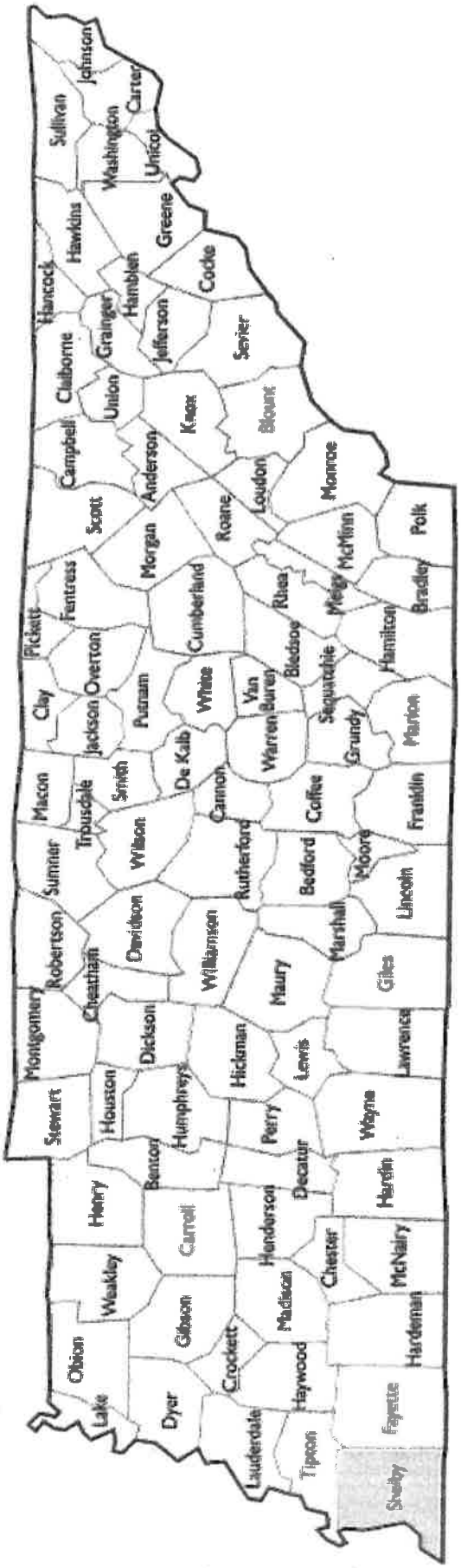
Currently, Shelby County is the primary service area for the Methodist psychiatric inpatient services. The relocation of the inpatient unit from Methodist University to Methodist North will not impact the service area. Methodist will continue to serve the Shelby County community as we have for over 40 years. Over 85% of inpatient admissions originate from Shelby County.

Please complete the following tables, if applicable:

	Historical Utilization-County Residents	% of total procedures
Shelby County	313	85%
Other TN Counties	24	6%
Other AR Counties	14	4%
Other MS Counties	11	3%
Other States	9	2%
Total	370	100%

Service Area Counties	Projected Utilization-County Residents	% of total procedures
Shelby County	285	85%
Other TN Counties	22	6%
Other AR Counties	13	4%
Other MS Counties	10	3%
Other States	8	2%
Total	337	100%

County Level Map



D. 1). a) Describe the demographics of the population to be served by the proposal.

b) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population- Current Year (2017)	Total Population- Projected Year (2021)	Total Population-% Change	*Target Population (18+) - Current Year (2017)	*Target Population (18+) - Project Year (2021)	*Target Population (18+)- % Change	*Target Population (18+) Projected Year as % of Total	Median Age (2010)	Median Household Income (2015)	Person Below Poverty Level (2015)	Person Below Poverty Level as % of Total (2015)	TennCare Enrollees	TennCare Enrollees as % of Total Population
Shelby County	964,804	986,423	2.24%	716,092	732,768	2.33%	74.29%	34.6	46,224	196,471	20.60%	281,655	29.19%
Service Area Total	964,804	986,423	2.24%	716,092	732,768	2.33%	74.29%	34.6	46,224	196,471	20.60%	281,655	29.19%
State of TN Total	6,887,572	7,179,512	4.24%	5,114,657	5,555,185	8.61%	74.38%	38.0	45,219	1,117,594	16.59%	1,559,209	22.63%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The applicant intends to focus on the psychiatric and medical needs of low-income, Medicare, and self-pay patients. Shelby County's population is made up of approximately 55% minorities; approximately 27% people aged 55+ and approximately 51% female. Methodist aims to serve any and all special needs of the proposed service area. Methodist serves the adult SPMI patient population which is a large Medicare psychiatrically disabled population. The patients that Methodist serves also tend to be noncompliant and are admitted on both a voluntary and non-voluntary basis. The applicant also cares for chronic and acute patients with comorbid medical condition that require a longer time to stabilize.

E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply

to projects that are solely relocating a service.

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Not Applicable. There are no existing and approved unimplemented services of similar healthcare providers in the service area that the applicant is aware of at this time.

F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Methodist Healthcare-Memphis Hospitals Psychiatry Utilization and Occupancy					
	2014	2015	2016	2020	2021
Discharges	441	388	370	337	375
Days	8467	7791	7336	6640	7388
Average Daily Census	23.20	21.35	20.04	18.19	20.24
Occupancy Rate	68%	63%	59%	54%	60%

Assumptions for Year 1

- **10% Utilization reduction in Year 1 due to slight disruption relocating unit.**

Assumptions for Year 2

- **11% Utilization rebound in Year 2 as services stabilize and continue existing referral patterns and admission processes.**

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

The CON filing fee calculated from Line D of the Project Costs Chart is $15,000; therefore a check for this amount accompanies the application.

2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Not applicable. This project does not include any leases.

3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Not applicable. This project does not include any fixed or moveable equipment.

4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

Please see referenced charts for consistent documentation of Construction Costs.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

A letter from the architect follows as Attachment B: Economic Feasibility A5.

a) A general description of the project;
b) An estimate of the cost to construct the project;
c) A description of the status of the site's suitability for the proposed project; and
d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority

PROJECT COST CHART

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A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$140,000
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$10,000
3.	Acquisition of Site	-
4.	Preparation of Site	
5.	Total Construction Costs	$1,384,375
6.	Contingency Fund	$221,500
7.	Fixed Equipment (Not included in Construction Contract)	-
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments – not applicable)	$250,000
9.	Other (Specify) Technology, furniture and escalation estimates	$274,125
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)	**$2,280,000**
E.	CON Filing Fee	$15,000
F.	Total Estimated Project Cost (D+E) **TOTAL**	**$2,295,000**

B. Identify the funding sources for this project. 48

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-B.)***

__	1)	Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
__	2)	Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
__	3)	General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;
__	4)	Grants – Notification of intent form for grant application or notice of grant award;
X	5)	Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or
__	6)	Other – Identify and document funding from all other sources.
		Methodist Healthcare is prepared to fund the project cost with cash reserves. See the attached letter from the Chief Financial Officer. Attachment C: Economic Feasibility B6

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

In 000's	Year 2014	Year 2015	Year 2016
A. Utilization Data (Discharges)	10,803	10,688	10,068
B. Revenue from Services to Patients			
1. Inpatient Services	$392,112	$401,124	$401,736
2. Outpatient Services	235,895	251,823	290,542
3. Emergency Services	73,366	64,819	62,005
4. Other Operating (Specify):	728	836	838
Gross Operating Revenue	$702,101	$718,601	$755,121
C. Deductions form Gross Operating Revenue			
1. Contractual	451,981	471,836	499,336
2. Provision for Charity	75,419	71,160	72,099
3. Provision for Bad Debt	23,559	24,221	24,276
Total Deductions	$550,959	$567,218	$595,710
NET OPERATING REVENUE	$151,142	$151,384	$159,411
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$39,435	$39,348	$41,514
b. Non-Patient Care	17,816	18,116	19,515
2. Physician's Salaries	204	170	227
3. Supplies	27,455	27,520	27,282
4. Rent			
a. Paid to Affiliates	(429)	(484)	(530)
b. Paid to Non-Affiliates	462	351	301
5. Management Fees			
a. Paid to Affiliates	558	583	576
b. Paid to Non-Affiliates			
6. Other Operating	29,830	31,180	34,146
Total Operating Expenses	$115,331	$116,784	$123,032
E. Earnings Before Interest, Taxes and Depreciation	$35,811	$34,600	$36,379
F. Non-Operating Expenses			
1. Taxes	$162	$196	$186
2. Depreciation	6,633	7,188	7,616
3. Interest	149	88	11
4. Other Non-Operating	16,524	$16,828	$19,024
Total Non-Operating Expenses	$23,468	$24,300	$26,836
NET INCOME (LOSS)	$12,343	$10,300	$9,543

Chart Continues Onto Next Page

NET INCOME (LOSS)		$ 12,343	$ 10,300	$ 9,543
G. Other Deductions	50			
1. Annual Principal Debt Repayment		$	$	$
2. Annual Capital Expenditure				
Total Other Deductions		$	$	$
NET BALANCE		$ 12,343	$10,300	$ 9,543
DEPRECIATION		$ 6,633	$ 7,188	$ 7,616
FREE CASH FLOW (Net Balance + Depreciation)		$ 18,976	$ 17,488	$ 17,158

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES In 000's		Year 2014	Year 2015	Year 2016
1.	Benefits	$14,525	$14,933	$14,936
2.	Contract Labor	104	202	2,445
3.	Repairs and Maintenance	2,505	2,845	2,817
4.	Professional Fees	207	356	264
5.	Contract Services	5,502	5,950	6,378
6.	Accounting Legal & Consulting	342	268	277
7.	Advertising	15		
8.	Dues and Subscriptions	33	63	62
9.	Education/Travel	120	127	171
10.	Utilities	1,611	1,593	1,631
11.	Insurance	894	774	1,051
12.	Food Services	1	2	1
13.	Laundry Services	642	678	652
14.	Print Shop	65	66	68
15.	Telephone	173	183	192
16.	Transcription	616	592	603
17.	Admin Cost Transfer and Allocation	1,361	1,368	1,365
18.	Associate Recruitment	52	28	249
19.	License/Accreditations Fees	44	72	55
20.	Minority Interest	376	424	344
21.	Misc Other	644	656	584
	Total Other Expenses	$29,830	$31,180	$34,146

□ Total Facility
X Project Only

HISTORICAL DATA CHART

Behavioral Health Unit

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

In 000's	**Year 2014**	**Year 2015**	**Year 2016**
A. Utilization Data	441	392	375
B. Revenue from Services to Patients			
1. Inpatient Services	$11,053	$10,408	$10,297
2. Outpatient Services			
3. Emergency Services			
4. Other Operating (Specify):			
Gross Operating Revenue	$11,053	$10,408	$10,297
C. Deductions form Gross Operating Revenue			
1. Contractual	$6,979	$5,222	$5,014
2. Provision for Charity	710	478	425
3. Provision for Bad Debt	288	212	176
Total Deductions	$7,977	$5,912	$5,615
NET OPERATING REVENUE	$3,076	$4,497	$4,682
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$1,849	$1,735	$1,707
b. Non-Patient Care	315	314	313
2. Physician's Salaries	33	33	33
3. Supplies	137	111	107
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
6. Other Operating	1,208	1,186	1,302
Total Operating Expenses	$3,541	$3,378	$3,462
E. Earnings Before Interest, Taxes and Depreciation	$(465)	$1,118	$1,220
F. Non-Operating Expenses			
1. Taxes			
2. Depreciation	19	21	14
3. Interest			
4. Other Non-Operating			
Total Non-Operating Expenses	$19	$21	$14
NET INCOME (LOSS)	$(484)	$1,098	$1,206

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ (484)	$ 1,098	$ 1,206
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$	$	$
NET BALANCE	$(484)	$ 1,098	$ 1,206
DEPRECIATION	$ 19	$ 21	$ 14
FREE CASH FLOW (Net Balance + Depreciation)	$(465)	$ 1,118	$1,220

☐ Total Facility

X Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES In 000's		Year 2014	Year 2015	*Year 2016*
1.	Benefits	$760	$720	$710
2.	Contract Labor	30	31	40
3.	Repairs and Maintenance	51	53	68
4.	Professional Fees	122	127	162
5.	Contract Services	155	161	205
6.	Utilities	31	33	42
7.	Insurance	26	28	35
8.	Laundry Services	8	9	11
9.	Print Shop	2	2	2
10.	Telephone	6	6	8
11.	Contributions	9	10	13
12.	License/Accreditations Fees	1	1	2
13.	Postage/Freight	4	4	6
	Total Other Expenses	$1,208	$1,186	$1,302

D. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

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PROJECTED DATA CHART

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

In 000's	Year 2020	Year 2021
A. Utilization Data Discharges	10,400	10,438
B. Revenue from Services to Patients		
1. Inpatient Services	$482,309	$502,791
2. Outpatient Services	315,002	330,816
3. Emergency Services	110,676	116,233
4. Other Operating (Specify):	839	847
Gross Operating Revenue	$ 908,825	$ 950,685
C. Deductions form Gross Operating Revenue		
1. Contractual	$621,490	$654,135
2. Provision for Charity	85,143	88,980
3. Provision for Bad Debt	28,580	29,772
Total Deductions	$735,213	$772,887
NET OPERATING REVENUE	$173,613	$177,798
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	$46,679	$48,109
b. Non-Patient Care	21,520	22,085
2. Physician's Salaries and Wages	279	286
3. Supplies	31,388	32,426
4. Rent		
a. Paid to Affiliates	(519)	(517)
b. Paid to Non-Affiliates	295	294
5. Management Fees		
a. Paid to Affiliates	444	447
b. Paid to Non-Affiliates		
6. Other Operating	36,775	37,518
Total Operating Expenses	$136,861	$140,648
E. Earnings Before Interest, Taxes and Depreciation	$36,752	$37,150
F. Non-Operating Expenses		
1. Taxes	$197	$197
2. Depreciation	10,400	10,860
3. Interest	(283)	(283)
4. Other Non-Operating	21,356	22,163
Total Non-Operating Expenses	$31,670	$32,937
NET INCOME (LOSS)	$5,082	$4,213

Chart Continues Onto Next Page

NET INCOME (LOSS)	55	$ 5,082	$ 4,213
G. Other Deductions			
1. Annual Principal Debt Repayment		$	$
2. Annual Capital Expenditure			
Total Other Deductions		$	$
NET BALANCE		$ 5,082	$ 4,213
DEPRECIATION		$ 10,400	$ 10,860
FREE CASH FLOW (Net Balance + Depreciation)		$ 15,482	$ 15,072

X Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES In 000's		Year 2020	Year 2021
1.	Benefits	$15,707	$16,196
2.	Contract Labor	2,803	2,885
3.	Repairs and Maintenance	3,093	3,109
4.	Professional Fees	601	636
5.	Contract Services	7,577	7,645
6.	Accounting Legal & Consulting	219	220
7.	Advertising		
8.	Dues and Subscriptions	45	45
9.	Education/Travel	108	108
10.	Utilities	1,784	1,793
11.	Insurance	1,165	1,173
12.	Food Services	1	1
13.	Laundry Services	638	646
14.	Print Shop	68	69
15.	Telephone	192	195
16.	Transcription	580	585
17.	Admin Cost Transfer and Allocation	1,315	1,326
18.	Associate Recruitment	240	242
19.	License/Accreditations Fees	54	55
20.	Minority Interest	5	(1)
21.	Contributions	11	14
22.	Misc Other	568	574
	Total Other Expenses	**$36,775**	**$37,518**

☐ Total Facility
X Project Only

PROJECTED DATA CHART

Behavioral Health Unit

Give information for the last 2 years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

In 000's	**Year 2020**	**Year 2021**
A. Utilization Data Discharges	337	375
B. Revenue from Services to Patients		
1. Inpatient Services	$10,735	$12,423
2. Outpatient Services		
3. Emergency Services		
4. Other Operating (Specify):		
Gross Operating Revenue	$10,735	$12,423
C. Deductions form Gross Operating Revenue		
1. Contractual	$5,771	$6,840
2. Provision for Charity	490	580
3. Provision for Bad Debt	203	241
Total Deductions	$6,464	$7,661
NET OPERATING REVENUE	$4,271	$4,762
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	$1,580	$1,811
b. Non-Patient Care	319	322
2. Physician's Salaries	33	33
3. Supplies	98	112
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
5. Management Fees		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating	1,207	1,417
Total Operating Expenses	$3,238	$3,695
E. Earnings Before Interest, Taxes and Depreciation	$1,032	$1,066
F. Non-Operating Expenses		
1. Taxes		
2. Depreciation	241	239
3. Interest	91	91
4. Other Non-Operating		
Total Non-Operating Expenses	$332	$330
NET INCOME (LOSS)	$700	$736

Chart Continues Onto Next Page

NET INCOME (LOSS)		$ 700	$ 736
G.	Other Deductions		
1.	Annual Principal Debt Repayment	$	$
2.	Annual Capital Expenditure		
	Total Other Deductions	$	$
	NET BALANCE	$ 700	$ 736
	DEPRECIATION	$241	$ 239
	FREE CASH FLOW (Net Balance + Depreciation)	$ 941	$ 975

☐ Total Facility

X Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES In 000's		Year 2020	Year 2021
1.	Benefits	$667	$749
2.	Contract Labor	36	45
3.	Repairs and Maintenance	62	76
4.	Professional Fees	148	183
5.	Contract Services	187	231
6.	Utilities	38	47
7.	Insurance	32	39
8.	Laundry Services	10	12
9.	Print Shop	2	3
10.	Telephone	7	9
11.	Contributions	11	14
12.	License/Accreditations Fees	2	2
13.	Misc other	5	6
	Total Other Expenses	$1,207	$1,417

E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$26,552	$27,460	$31,853	$33,127	21%
Deduction from Revenue *(Total Deductions/Utilization Data)*	$15,081	$14,974	$19,181	$20,430	36%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$11,471	$12,485	$12,673	$12,698	2%

2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

There will be no change to the existing charge structure as a result of this project, yet there will be normal unrelated rate increases over the next several years. The historical and proposed charges per discharge are shown in the table above which projects minimal increase in net operating revenue over the five year period. See the current room and bed charges below.

Charge/Procedure	Current Rate
ROOM AND BED	
PSYCH PRIVATE R&B	$ 1,147
PSYCH SEMI-PRIVATE R&B	$ 1,117

3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Based upon the review, the proposed gross and net revenue per discharge are reasonable and comparable to other Tennessee facilities. There will be no impact to the charge structure due to this project. The table below shows the comparison of charges/revenue based on recently approved Certificates of Need for Psychiatric facilities.

Facility/CON	CON	Project Year	Gross Oper Rev per Discharge	Net Oper Rev per Discharge
Methodist North Hospital	Proposed project	2020	$31,853	$12,673
Crestwyn Behavioral Health	CN1310-040	2015	$13,804	$7,799
TriStar Maury Regional Behavioral Health	CN1610-036	2018	$36,831	$8,266
Parkridge West Hospital	CN1611-039	2018	$28,748	$3,603

F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-F1. NOTE: Publicly held entities only need to reference their SEC filings.**

All cash is held at the corporate level, see the attached Methodist Le Bonheur Healthcare December 2016 Balance Sheet (Attachment B: Economic Feasibility F1) for the financial viability of the health system. The projections in this application show the Hospital and Psychiatric inpatient service will remain financially viable with breakeven by year 1 (2020). Methodist North Hospital is an integral part of Methodist Healthcare-Memphis Hospitals currently with 246 of the total 1,593 licensed beds. This investment will contribute to the long term viability and sustainability of the campus.

2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	-0.15	0.25	0.26	0.24	0.22

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt+Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

The Capitalization Ratio for MLH 2016 Audited Financial Statements is 0.26.

G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$10,367,781	96.6%
TennCare/Medicaid	33,209	0.3%
Commercial/Other Managed Care	20,529	0.2%
Self-Pay	-	-
Charity Care	-	-
VA	312,992	2.9%
Total	$10,734,510	100.0%

H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Position Classification	Existing FTEs (2016)	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
a) Direct Patient Care Positions				
Activity Coordinator	0.6	0.5	$20.92	$20.92
Mental Health Counselor	1.0	1.0	$27.99	$22.18
Mental Health Technician	10.8	8.0	$15.70	$14.32
Patient Care Coord/ Variable	1.1	1.0	$38.28	$46.96
RN	11.2	10.0	$31.83	$30.86
Total Direct Patient Care Positions	24.7	20.5		

Position Classification	Existing FTEs (2016)	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage*
b) Non-Patient Care Positions				
Case Manager	1.5	1.0	$26.62	$33.40
Security	4.2	4.2	$14.22	$13.13
Maintenance	2.2	2.2	$17.23	$17.34
Total Non-Patient Care Positions	7.9	7.4		
Total Employees *(A+B)*	32.6	27.9		
c) Contractual Staff	-	-		
Total Staff *(a+b+c)*	32.6	27.9		

*US Bureau of Labor Statistics

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

- **The unit is currently housed on the 8th Floor of Crews Wing at Methodist University Hospital which is scheduled for demolition summer 2019. Since Methodist is committed to maintaining psychiatric inpatient services for the community, new locations were considered. The possibilities were narrowed to the Methodist University campus in Thomas Wing, and the Methodist North campus.**
- **This project was the more cost effective location and less disruptive option for the relocation. The proposed location is attached to the main hospital but contained as singular space; it has a covered entrance and close parking. The building is isolated from the rest of the general hospital with a separate entrance. The secured, controlled access makes it an optimal setting for psychiatric services to ensure privacy and security. Renovations on the North campus were less extensive since it is a separate space.**
- **While it is separate, it is adjacent to the hospital with close proximity to support services such as environmental services, security and food and nutrition.**
- **The proposed location provides more square footage for the service line adding more expansive group therapy and activities space and a larger environment of care.**

2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

There is no new construction. The building on the North campus will be renovated with new finishes and fixtures including architectural features to reduce ligature risk and prevent patients from harming themselves. Renovations are minimal.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

- **The Methodist Healthcare-Memphis Hospitals' license includes five hospitals-**
  - **Methodist University Hospital**
  - **Methodist South Hospital**
  - **Methodist North Hospital**
  - **Methodist Le Bonheur Germantown Hospital**
  - **Le Bonheur Children's Hospital**
- **Additionally, Methodist Healthcare-Memphis Hospitals owns and operates Methodist Alliance Services, a comprehensive home care company, and a wide array of other ambulatory services such as urgent care centers and ambulatory surgery centers.**
- **Methodist Healthcare is part of the University Medical Center Alliance which also includes the University of Tennessee and the Memphis Regional Medical Center (The Med). The goal of this council is to support the quality of care, patient safety and efficiency across all three institutions.**
- **There are also agreements with the Mid-South Tissue Bank, the Mid-South Transplant Foundation, and PhyAmerica.**
- **Methodist Healthcare has working relationships with the following physician groups:**
  - **The West Clinic**
  - **UT Medical Group, Inc.**
  - **UT Le Bonheur Pediatric Specialists**
  - **Campbell Clinic Orthopaedics**
  - **Pediatric Anesthesiologists PA**
  - **Pediatric Emergency Specialists PC**
  - **Semmes-Murphey Neurologic and Spine Institute**
  - **Methodist Primary and Specialty Care Groups**

B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

The proposed project will have a positive impact on the Shelby County health care community. The project is the relocation of established psychiatric services and affirms Methodist's commitment to continue to provide psychiatric services in the service area in a larger, newly renovated space.

2) Negative Effects

The project will not negatively affect any providers in the service area. These are existing Methodist beds which will be relocated within the same hospital system less than 14 miles away.

C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Currently, Methodist's psychiatric beds are located and operated at Methodist University Hospital. With this proposed relocation not only would the beds be relocated, but all the clinical leadership, professional staff, and accessibility to human resources would be relocated as well.

The applicant projects a total of 27.91 associated in the project's first full calendar year of operation. All current staff will be relocated along with the beds and service to the proposed location. FTEs are not added with this project.

2) Verify that the applicant has reviewed and understands all licensing and certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so verifies. Methodist North Hospital reviewed and meets all the State requirements for physician supervision, credentialing, admission privileges, and quality assurance policies and programs, utilization review policies and programs, record keeping and staff education.

3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Methodist Healthcare has clinical affiliation agreements with multiple colleges including twenty for nursing, thirty for rehabilitation service professionals (physical therapy, speech therapy, and audiology), three for pharmacy, and almost twenty for other allied health professionals including paramedics, laboratory, respiratory therapy, radiation therapy technicians.

Methodist participates very heavily in the training of students from various medical disciplines. Since relationships exist with most of the schools in Memphis, most of the students have also been trained academically in this region. The three primary disciplines that participate in the training of students at Methodist are medicine, nursing and psychosocial services.

In the area of medicine, there are many different specialties represented in the interns and residents who train at Methodist – there are more than twenty different specialties. Likewise, since there are several nursing schools in the area, Methodist is very active in the training of future nurses. These nurses come from several types of programs, which include Bachelor's Degrees, Associate Degrees, Licensed Practical Nurse programs and Diploma programs. Methodist participates in training of students from the following schools:

Methodist Healthcare
University of Tennessee
University of Memphis
Northwest Mississippi Jr. College
Baptist Health System
Regional Medical Center
Southwest Tennessee Community College
Tennessee Centers of Technology

D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: **State of Tennessee Hospital Licensure Survey in 2008 (see Attachment Orderly Development D for current license and Licensure Survey)**

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): **Medicare Hospital**

Accreditation (i.e., Joint Commission, CARF, etc.): **DNV GL-Healthcare**

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.
   - **Full accreditation by DNV-GL Healthcare; Effective: 2/27/2017 – 2/27/2020 (see Attachment Orderly Development D1 for accreditation letter and certificate)**

2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.
   - **See Attachment Orderly Development D1 for accreditation letter and certificate**

3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

   In March 2016 we received a notice of 23-day termination proceedings related to inappropriate use of force by a security officer at Methodist North Hospital. The hospital's Plan of Correction was accepted by CMS, and the follow-up survey on 4/5/2016 determined we were in full compliance with the Medicare Conditions of Participation (see Attachment Orderly Development D2 for CMS Letter of Compliance).

   a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.
      Under the leadership of a newly appointed system director of Environmental Health and Security, the hospital instituted an ongoing QAPI program for the Security Department. In addition, policies and procedures, training and competency for security officers were standardized.

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

   a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

      There is no person (s) or entity with more than 5% ownership (direct or indirect) in the applicant.

   b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

      There is no entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

   c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

      There is no physician or other provider of health care, or administrator employed

by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

2) Been subjected to any of the following:

a) Final Order or Judgment in a state licensure action;

There is no Final Order or Judgment in a state licensure action.

b) Criminal fines in cases involving a Federal or State health care offense;

There are no criminal fines in cases involving a Federal or State health care offense.

c) Civil monetary penalties in cases involving a Federal or State health care offense;

There are no civil monetary penalties in cases involving a Federal or State health care offense.

d) Administrative monetary penalties in cases involving a Federal or State health care offense;

There are no administrative monetary penalties in cases involving a Federal or State health care offense.

e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

There is no agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services.

f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

There is no Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

There is presently no subject of/to an investigation, regulatory action, or party in any civil or criminal action of which we are aware.

h) Is presently subject to a corporate integrity agreement.
The applicant is not presently subject to a corporate integrity agreement.

F. Outstanding Projects:

1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s) Due Date	*Annual Progress Report(s) Date Filed	Expiration Date
CN1503- 008	MH- South ED Expansion and Renovation	6/24/2015	7/2017	7/13/2017	8/1/2018
CN-1602-009	MH- University Onsite Replacement and Modernization of Hospital Campus	5/25/2016	8/2017	7/13/2017	7/1/2020

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

- **CN1503- 008 (MH- South ED Expansion and Renovation) was scheduled in four phases: Phase 1: Helipad relocation; Phase 2: New construction of expanded ED; and Phase 3 & 4: Phased renovation of existing ED. All Phases are 100% complete. The hospital is working with the State of Tennessee for final approval this month. The project will be complete August 2017. The project is within the proposed budget.**
- **CN-1602-009 (MH- University Onsite Replacement and Modernization of Hospital Campus) is scheduled in two phases: 1) Renovation of existing hospital and 2) Construction of new tower. The design for the project is 100% complete. The project is on schedule and within proposed budget. The overall completion date for the entire project is December 2019.**

G. Equipment Registry – For the applicant and all entities in common ownership

1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? **Yes**

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission? **3/30/2017**

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? **3/30/2017**

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

The applicant will annually report continued need and appropriate quality measures as the Agency sees fit.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

This project involves relocating already existing licensed beds in the same county within the same hospital system. Methodist has improved the health of the community with these beds for over 40 years and wants to continue to do so.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

By relocating these beds, Methodist will be able to utilize a space that is attached to our facility but is contained as a singular space. There is a covered entrance and close parking as well as easy access for support services such as EVS, Security, Food and Nutrition. The unit will continue to be connected to a general hospital to serve additional medical needs. Methodist also has a strong referral network that is able to connect patients to other providers so that they can achieve optimal health and continued care.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Methodist continues to encourage economic efficiencies with the patients that they current see and will continue to do so if this application is approved. This project was the more cost effective location and less disruptive option for the relocation. The

proposed location is attached to the main hospital but contained as singular space. The secured, controlled access makes it an optimal setting for psychiatric services to ensure privacy and security. Renovations on the North campus were less extensive since it is a separate space.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

The applicant's 34 psychiatric beds have been in operation for over 40 years. The longevity of this unit and program is evidence that this facility provides high quality healthcare and its standards are monitored on an ongoing basis. The applicant provides a quality improvement program that includes outcomes and process monitoring systems and currently reports all quality metrics to DNV. The applicant is engaged in reporting this data on an ongoing and regular basis.

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Methodist Healthcare has clinical affiliation agreements with multiple colleges including twenty-three for nursing, thirty for rehabilitation service professionals (physical therapy, speech therapy, and audiology), three for pharmacy, and nineteen for other allied health professionals including paramedics, laboratory, respiratory therapy, radiation therapy technicians. These affiliations represent the dedication that Methodist has to supporting the efforts of developing, recruiting, and retaining sufficient and quality associates.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   See the Project Completion Forecast Chart on the following page.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Not applicable

SUPPLEMENTAL #1
September 25, 2017
10:29 am

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		12/2017
2. Architectural and engineering contract signed	30	1/2018
3. Construction documents approved by the Tennessee Department of Health	60	7/2018
4. Construction contract signed	15	7/2018
5. Building permit secured	15	8/2018
6. Site preparation completed	NA	NA
7. Building construction commenced	180 total	12/2018
8. Construction 40% complete	90	2/2019
9. Construction 80% complete	160	5/2019
10. Construction 100% complete (approved for occupancy	180	6/2019
11. *Issuance of License	30	7/2019
12. *Issuance of Service	30	7/2019
13. Final Architectural Certification of Payment	1	9/2019
14. Final Project Report Form submitted (Form HR0055)	1	9/2019

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		12/2017
2. Architectural and engineering contract signed	30	1/2018
3. Construction documents approved by the Tennessee Department of Health	60	7/2018
4. Construction contract signed	15	7/2018
5. Building permit secured	15	8/2018
6. Site preparation completed	NA	NA
7. Building construction commenced	180 total	12/2018
8. Construction 40% complete	90	2/2019
9. Construction 80% complete	160	5/2019
10. Construction 100% complete (approved for occupancy	180	6/2019
11. *Issuance of License	30	7/2019
12. *Issuance of Service	30	7/2019
13. Final Architectural Certification of Payment	1	9/2019
14. Final Project Report Form submitted (Form HR0055)	1	9/2019

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

SEP 26 '17 PM 1:4

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF SHELBY

NAME OF FACILITY: METHODIST HEALTHCARE – MEMPHIS HOSPITALS, DBA METHODIST NORTH HOSPITAL

I, FLORENCE JONES, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Florence Jones, President
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 25 day of September 2017, witness my hand at office in the County of Shelby, State of Tennessee.

Nancy Slone
NOTARY PUBLIC

My commission expires My Commission Expires January 20, 2019

NANCY SLONE STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

HF-0043

Revised 7/02

ATTACHMENTS

INDEX OF ATTACHMENTS

A:3.C	Consent Calendar Request
A:4A-1	Corporate Charter and Certificate of Existence
A:4A-2	Ownership-Legal Entity and Organization Chart
A:6A	Site Control
A:6B-1	Plot Plan
A:6B-2	Floor Plans
A:6B-3	Public Transportation Routes
B: Economic Feasibility A5	Documentation of Construction Cost Estimate
B: Economic Feasibility B6	Documentation of Availability of Funding
B: Economic Feasibility F1	Audit Report and Financial Statements
B: Orderly Development D	License from Board of Licensing Health Care Facilities and Licensure Survey
C: Orderly Development D1	DNV Accreditation Letter and Certificate
C: Orderly Development D2	CMS Letter of Compliance
C: Proof of Publication	Proof of Publication

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A:3.C

Consent Calendar Request

Methodist Healthcare

September 14, 2017

Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Methodist Le Bonheur Healthcare, centered in Shelby County, is one of Tennessee's largest healthcare providers. Methodist Healthcare's principal acute care subsidiary organization is Methodist Healthcare--Memphis Hospitals that owns and operates five Shelby County hospitals. Methodist North Hospital is the 246-bed adult facility located in the northern quadrant of the Methodist service area. Methodist North is filing a Certificate of Need for the relocation of the 34-bed Methodist Psych inpatient unit currently located on the Methodist University Hospital campus to the Methodist North campus.

Methodist would like to request this project for the Consent Calendar for the reasons noted below:

- The need for this project is supported by the State Health Plan, as these are existing beds and Methodist is not proposing new beds or new services. All Need, Financial, Development and Quality criteria are met with the proposal.
- Methodist has operated the psychiatric unit since 1973, and is committed to continue high quality and cost effective services.
- Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. The demolition of the Crews building – where the psychiatric unit is housed – will force the relocation of the program and beds.
- The choice to relocate the 34 beds to a hospital within the same system, only 13.7 miles away, allows Methodist to serve the same community with the same resources. The full program including equipment, staff, and physicians be relocated simultaneously.
- There are no negative implications with the proposal for the Methodist program, referral sources or competitors and most importantly patients.
- The applicant is relocating further away that all other competitors except

Lakeside Behavioral Health System. Although the location is closer to Lakeside, they offer broader, complimentary services including substance abuse, chemical dependency as well as adolescent and geriatric inpatient beds. Methodist has a positive working and referral relationship with Lakeside.

	Methodist University	Methodist North
Lakeside Behavioral Health System	21.0 miles	9.2 miles
Delta Medical Center	11.8 miles	17.1 miles
St. Francis Hospital - Park	12.7 miles	12.7 miles
Crestwyn Behavioral Health Hospital	21.8 miles	22.7 miles

- This project is economically feasible. The projections in this application show Methodist North Hospital and psychiatric inpatient service will remain financially viable with breakeven by year 1 (2020).

Methodist North Hospital is an integral part of Methodist Healthcare-Memphis Hospitals currently with 246 of the total 1,593 licensed beds. This investment will contribute to the long term viability and sustainability of the campus as well as the well-established psychiatric program.

We respectfully request your consideration.

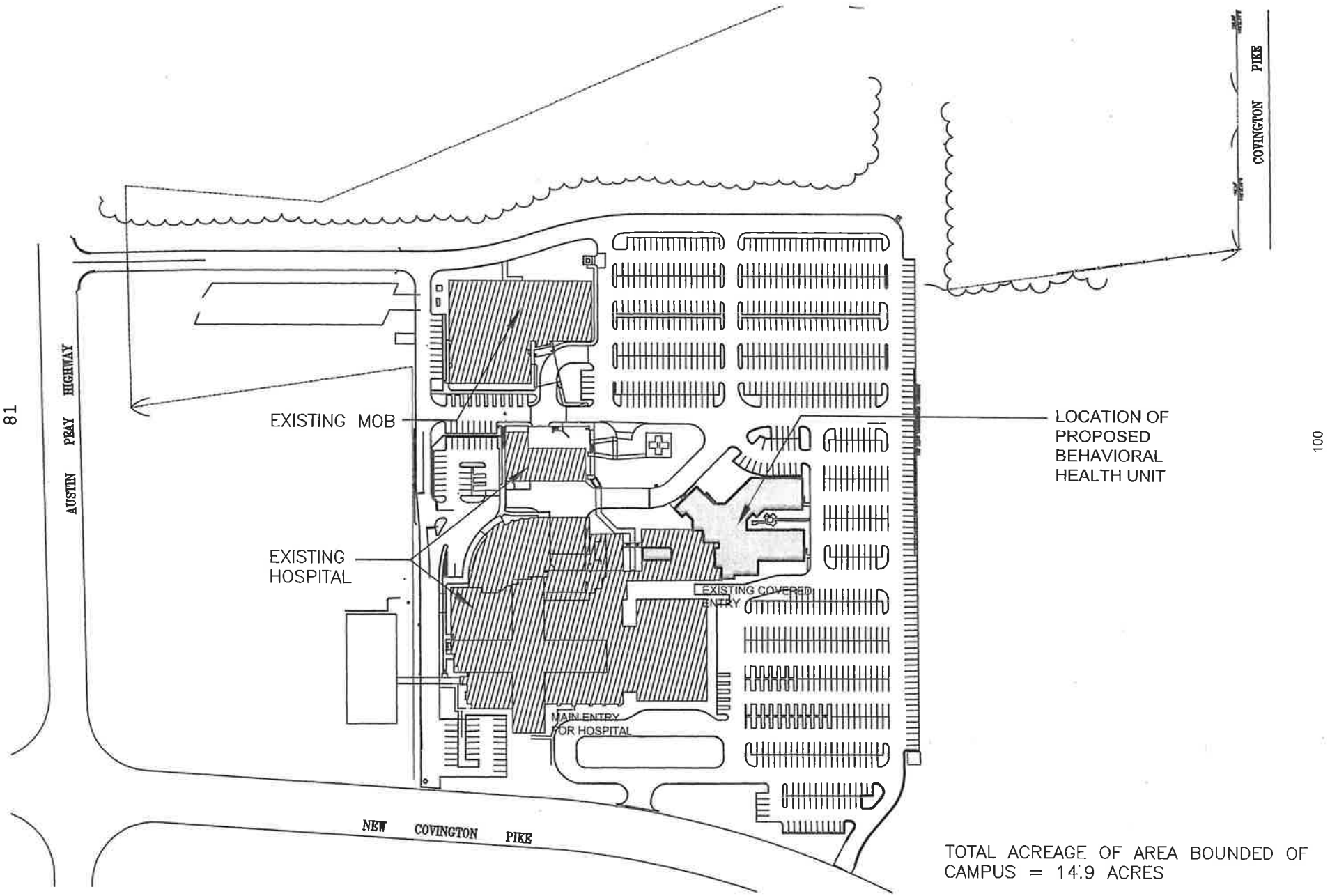
Sincerely,

Carol Weidenhoffer
Senior Director of Planning and Business Development

A:6B-1

Plot Plan

Site Plan



TOTAL ACREAGE OF AREA BOUNDED OF CAMPUS = 14.9 ACRES

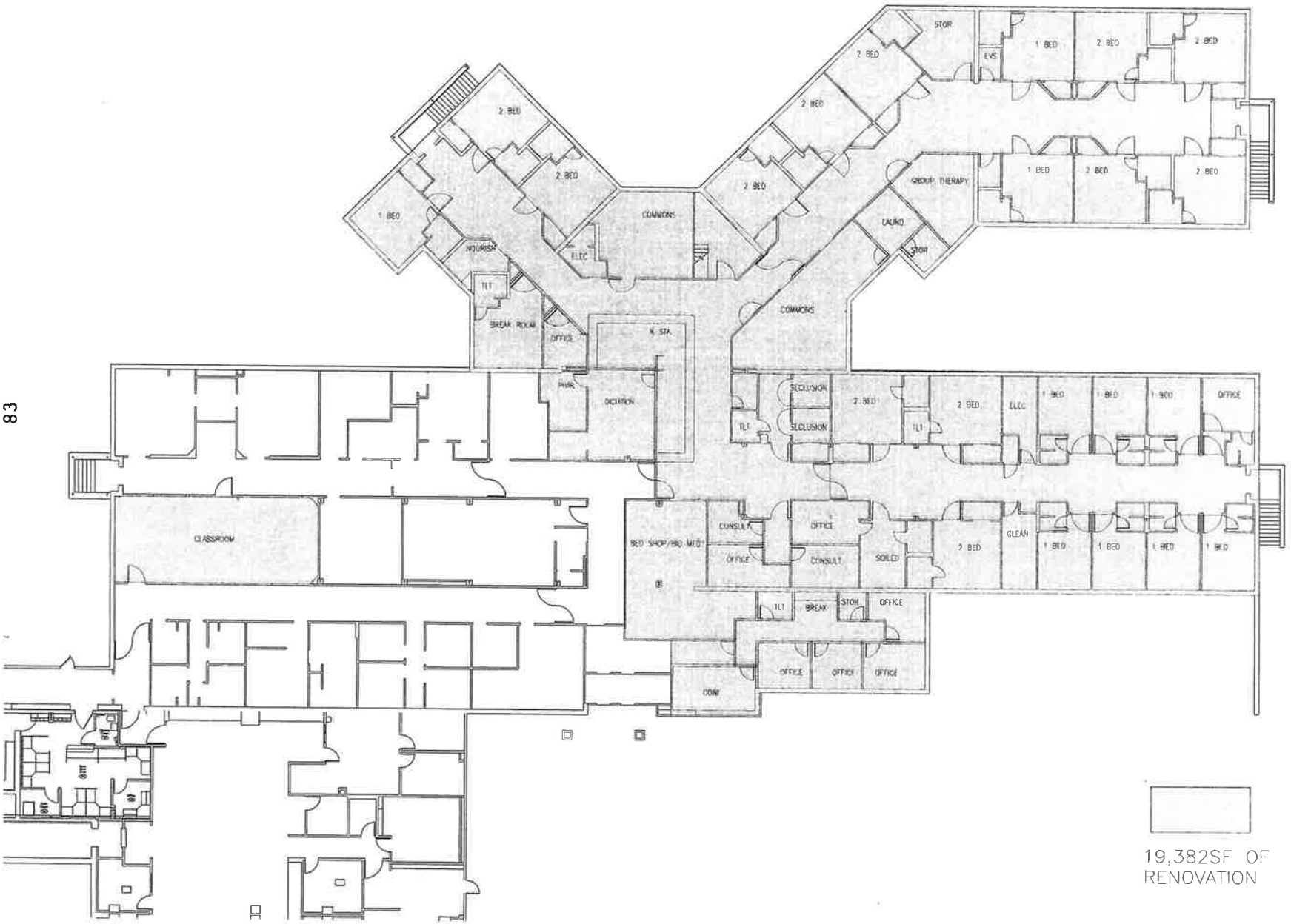
Methodist North Hospital Behavioral Health Unit 08.04.17

brg:as architects

A:6B-2

Floor Plans

Floor Plan



83

102

19,382SF OF RENOVATION

Methodist North Hospital Behavioral Health Unit 08.04.17

brgarchitects

B: Economic Feasibility A5

Documentation of Construction Cost Estimate

September 8, 2017
Commission No.: 2017552

Methodist Le Bonheur Healthcare
Richard Kelley
1350 Concourse Ave Suite 668
Memphis, TN 38104

Re: Verification of Construction Cost Estimate –
Relocation of Behavioral Health Unit to Methodist North Hospital,
Memphis, Tennessee

Dear Richard:

We have reviewed the construction cost estimates and descriptions for the project in the CON packet and compared them to typical construction costs we have experienced in the Mid South region for healthcare construction.

We believe that in today's dollar the projected cost of construction of $1.7 million is consistent with the costs value for this scope of work and other similar projects in this market. The budget includes $1.4 million for construction, $0.2 million in contingency and $0.1 million in design fees. While specific finish choices and market conditions can greatly affect the cost of any project, the costs assumed in the estimate appear adequate for mid range finishes used in a healthcare environment for the scope of work for the Behavioral Health Unit the ground floor of Methodist North Hospital.

In providing opinions of probable construction cost, the Client understands the Consultant has no control over the cost or availability of labor, equipment or material, or over market conditions or the Contractor's method of pricing and that the Consultant's opinions of probable construction costs are made on the basis of the Consultants professional judgment and experience. The consultant makes no warranty, express or implied, that the bids or the negotiated cost of the work will not vary from the Consultant's opinion of probable construction cost.

This facility will be designed in accordance with all applicable codes, regulations and guidelines required and in accordance with equipment manufacturer's specifications at the proposed location of the Behavioral Health Unit at Methodist North Hospital.

Please let me know if you require additional information.

Sincerely,

brg3s

Susan Golden
Architect

11 W. Huling Avenue
Memphis, Tennessee 38103
t 901.260.9600
f 901.531.8042
w brg3s.com

brg3s

B: Economic Feasibility B6

Documentation of Availability of Funding

Methodist Healthcare

September 12, 2017

Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

This is to certify that Methodist Healthcare – Memphis Hospitals has adequate financial resources for the Methodist North Hospital Relocation of Psychiatric Inpatient Unit project. The applicant, Methodist Healthcare – Memphis Hospitals, is a not-for-profit corporation that operates five Shelby County hospitals under a single license. The applicant is a wholly-owned subsidiary of a broader parent organization, Methodist Le Bonheur Healthcare, which is a not-for-profit corporation with ownership and operating interests in multiple other healthcare facilities of several types in West Tennessee, North Mississippi and East Arkansas. Cash is held at the corporate level. Methodist Le Bonheur Healthcare has available cash balances to commit to this project. The capital cost of the project is estimated at $2,295,000.

Sincerely,

Chris McLean
Chief Administrative Officer

B: Economic Feasibility F1

Audit Report and Financial Statements

KPMG

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Combined Financial Statements

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Table of Contents

KPMG LLP
Triad Centre III
Suite 450
6070 Poplar Avenue
Memphis, TN 38119-3901

Independent Auditors' Report

The Board of Directors
Methodist Le Bonheur Healthcare:

We have audited the accompanying combined financial statements of Methodist Le Bonheur Healthcare and Affiliates (the System), which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Methodist Le Bonheur Healthcare and Affiliates as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Memphis, Tennessee
April 28, 2017

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Combined Balance Sheets

December 31, 2016 and 2015

(In thousands)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 67,239	137,461
Investments	927,314	853,076
Assets limited as to use – current portion	796	650
Net patient accounts receivable	231,441	216,351
Other current assets	89,262	75,005
Total current assets	1,316,052	1,282,543
Assets limited as to use, less current portion	32,798	36,485
Property and equipment, net	954,533	921,000
Other assets	52,977	41,139
Total assets	$ 2,356,360	2,281,167
Liabilities and Net Assets		
Current liabilities:		
Accounts payable	$ 82,350	100,758
Accrued expenses	98,289	92,265
Due to third-party payors, net	10,148	101
Long-term debt – current portion	19,971	17,046
Total current liabilities	210,758	210,170
Long-term debt, less current portion	507,432	540,821
Estimated professional and general liability costs	11,353	11,210
Accrued pension cost	115,434	112,841
Other long-term liabilities	66,282	73,020
Total liabilities	911,259	948,062
Net assets:		
Unrestricted	1,410,314	1,305,124
Temporarily restricted	28,899	22,150
Permanently restricted	3,641	3,641
Total net assets attributable to Methodist Le Bonheur Healthcare	1,442,854	1,330,915
Noncontrolling interests	2,247	2,190
Total net assets	1,445,101	1,333,105
Commitments and contingencies		
Total liabilities and net assets	$ 2,356,360	2,281,167

See accompanying notes to combined financial statements.

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Combined Statements of Operations

Years ended December 31, 2016 and 2015

(In thousands)

	2016	2015
Unrestricted revenues and other support:		
Net patient service revenue	$ 1,932,456	1,882,749
Provision for uncollectible accounts	(170,637)	(163,509)
Net patient service revenue less provision for uncollectible accounts	1,761,819	1,719,240
Other revenue	160,585	142,789
Net assets released from restrictions used for operations	11,635	11,451
Total unrestricted revenues and other support	1,934,039	1,873,480
Expenses:		
Salaries and benefits	949,554	876,746
Supplies and other	792,126	735,515
Depreciation and amortization	108,266	106,017
Interest	20,608	25,489
Total expenses	1,870,554	1,743,767
Operating income	63,485	129,713
Nonoperating gains (losses):		
Investment income, net	25,017	36,925
Change in fair value of interest rate swaps	6,578	1,012
Unrealized gain (loss) on trading securities, net	20,608	(28,732)
Loss on refunding of long-term debt	(8,610)	—
Total nonoperating gains, net	43,593	9,205
Revenues, gains and other support in excess of expenses and losses, before noncontrolling interests	107,078	138,918
Noncontrolling interests	(1,426)	(1,535)
Revenues, gains and other support in excess of expenses and losses	105,652	137,383
Other changes in unrestricted net assets:		
Accrued pension cost adjustments	(2,593)	5,671
Other	21	—
Net assets released from restrictions used for capital purposes	2,110	2,394
Change in unrestricted net assets	$ 105,190	145,448

See accompanying notes to combined financial statements.

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Combined Statements of Changes in Net Assets

Years ended December 31, 2016 and 2015

(In thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Noncontrolling interests	Total
Balances at December 31, 2014	$ 1,159,676	24,597	3,704	2,498	1,190,475
Revenues, gains and other support in excess of expenses and losses	137,383	—	—	1,535	138,918
Distributions to minority shareholders	—	—	—	(1,843)	(1,843)
Accrued pension cost adjustments	5,671	—	—	—	5,671
Donor-restricted gifts, grants, and bequests	—	11,551	(63)	—	11,488
Investment income, net	—	(153)	—	—	(153)
Net assets released from restrictions used for operations	—	(11,451)	—	—	(11,451)
Net assets released from restrictions used for capital purposes	2,394	(2,394)	—	—	—
Change in net assets	145,448	(2,447)	(63)	(308)	142,630
Balances at December 31, 2015	1,305,124	22,150	3,641	2,190	1,333,105
Revenues, gains and other support in excess of expenses and losses	105,852	—	—	1,426	107,078
Distributions to minority shareholders	—	—	—	(1,369)	(1,369)
Accrued pension cost adjustments	(2,593)	—	—	—	(2,593)
Donor-restricted gifts, grants, and bequests	—	18,216	—	—	18,216
Investment income, net	—	2,278	—	—	2,278
Other	21	—	—	—	21
Net assets released from restrictions used for operations	—	(11,635)	—	—	(11,635)
Net assets released from restrictions used for capital purposes	2,110	(2,110)	—	—	—
Change in net assets	105,190	6,749	—	57	111,996
Balances at December 31, 2016	$ 1,410,314	28,899	3,641	2,247	1,445,101

See accompanying notes to combined financial statements.

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In thousands)

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 111,996	142,630
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	108,266	106,017
Unrealized and realized (gain) loss on trading securities, net	(22,387)	14,758
Change in fair value of interest rate swaps	(6,578)	(1,012)
Provision for uncollectible accounts	170,637	163,509
Restricted contributions and investment income	(3,143)	(1,272)
Equity in net loss of equity investees	7,344	9,017
Impairment of land	570	110
Gain on disposal of property and equipment	(376)	(21)
Accrued pension cost adjustments	2,593	(5,671)
Changes in operating assets and liabilities, net of effects of acquisitions:		
Accounts receivable	(185,727)	(165,826)
Other current assets	(14,257)	(13,312)
Other assets	(19,851)	(3,011)
Accounts payable, accrued expenses and due to third-party payors	(2,354)	(5,350)
Other long-term liabilities, estimated professional and general liability costs and accrued pension costs	(17)	(7,196)
Net cash provided by operating activities	146,716	233,370
Cash flows from investing activities:		
Capital expenditures	(142,141)	(125,854)
Proceeds from sales of property and equipment	944	328
Sales of investments and assets limited as to use	1,980,415	1,735,527
Purchases of investments and assets limited as to use	(2,028,725)	(1,822,371)
Purchase of businesses	(716)	—
Net cash used in investing activities	(190,223)	(212,370)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	119,675	552
Repayment of long-term debt	(19,763)	(15,492)
Cash defeasance of debt	(129,770)	—
Restricted contributions and investment income	3,143	1,272
Net cash used in financing activities	(26,715)	(13,668)
Net (decrease) increase in cash and cash equivalents	(70,222)	7,332
Cash and cash equivalents at beginning of year	137,461	130,129
Cash and cash equivalents at end of year	$ 67,239	137,461

See accompanying notes to combined financial statements.

METHODIST LE BONHEUR HEALTHCARE AND AFFILIATES

Notes to Combined Financial Statements

December 31, 2016 and 2015

(1) Organization and Summary of Significant Accounting Policies

Methodist Le Bonheur Healthcare and Affiliates (the System) is a not-for-profit healthcare system providing a continuum of healthcare services primarily to residents of Memphis, West Tennessee, North Mississippi, and East Arkansas through its acute care and specialty care facilities. The System operates six hospitals, a hospice residence and a home health agency, with over 13,200 employees and 1,680 licensed beds. The significant accounting policies used by the System in preparing and presenting its combined financial statements follow:

(a) Principles of Combination

The accompanying combined financial statements include Methodist Le Bonheur Healthcare (Methodist Le Bonheur), all affiliates for which Methodist Le Bonheur or its board of directors is the controlling member, and its wholly owned subsidiaries. Such affiliates and subsidiaries of the System include:

- Methodist Healthcare – Memphis Hospitals (Methodist Healthcare – University Hospital, North Hospital, South Hospital, Germantown Hospital and Le Bonheur Children's Hospital);
- Methodist Healthcare – Fayette Hospital (closed in fiscal year 2015);
- Methodist Healthcare – Olive Branch Hospital;
- Alliance Health Services, Inc.;
- Methodist Extended Care Hospital, Inc. (closed in fiscal year 2016);
- Methodist Le Bonheur Healthcare Foundation (comprised of Methodist Healthcare Foundation, Le Bonheur Children's Hospital Foundation, and Le Bonheur Community Health and Well-Being);
- Methodist Healthcare Community Care Associates;
- Methodist Healthcare Primary Care Associates; and
- Ambulatory Operations, Inc.

ASU 2010-07 also requires that noncontrolling ownership interests in subsidiaries held by parties other than the parent be clearly identified, labeled, and presented in the combined balance sheets within net assets, but separate from the entity's net assets. In addition, ASU 2010-07 requires that a combined statement of changes in net assets attributable to the entity and noncontrolling interests be provided for each class of net assets for which a noncontrolling interest exists during the reporting period.

All significant intercompany balances and transactions have been eliminated in combination.

(b) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires that management make estimates and assumptions affecting the reported amounts of assets, liabilities, revenues and expenses, as well as disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

(Continued)

C: Orderly Development D1

DNV Accreditation Letter and Certificate

DNV·GL

March 7, 2017

Michael Ugwueke
Chief Executive Officer
Methodist Healthcare Memphis Hospitals
d/b/a Methodist University Hospital
1265 Union Avenue
Memphis, TN 38104

Program: Hospital
CCN: 440049
Survey Type: Medicare Recertification/ DNVHC First DNV Initial
Certificate #: 215075-2017-AHC-USA-NIAHO
Survey Dates: January 24-26, 2017
Accreditation Decision: Full accreditation
Date Acceptable Plan of Correction Received: 2/27/2017
Method of Follow-up: Acceptable Plan of Correction, Self- Attestation, Document Review
Effective Date of Accreditation: 2/27/2017
Expiration Date of Accreditation: 2/27/2020
Term of Accreditation: Three (3) years

Dear Mr. Ugwueke:

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Methodist Healthcare Memphis Hospitals d/b/a Methodist University Hospital is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482) and awarded full accreditation for a three (3) year term effective on the date referenced above DNV GL Healthcare USA, Inc. is recommending your organization for continued deemed status in the Medicare Program.

This accreditation is applicable to all facilities operating under the above-referenced CCN number at the following address(es):

Methodist Healthcare Memphis Hospitals d/b/a Methodist University Hospital - 1265 Union Avenue - Memphis, TN 38104
Le Bonheur Children's Hospital – 848 Adams Street - Memphis, TN 38103
Methodist Le Bonheur Germantown Hospital - 7691 Poplar Avenue – Germantown, TN 38138
Methodist North Hospital - 3960 New Covington Pike - Memphis, TN 38128
Methodist South Hospital - 1300 Wesley Drive - Memphis, TN 38116
Methodist Diagnostic Center – Midtown - 1801 Union Avenue - Memphis, TN 38104
Methodist Medical Group & MHMH GI Lab (DBA: Southwind Medical Specialists) - 3725 Champion Hills Drive Suite 2000 & 2400 - Memphis, TN 38125
South Comprehensive Wound Healing Center - 1251 Wesley Drive Suite 107 - Memphis, TN 38125
North Comprehensive Wound Healing Center - 3950 New Covington Pike Suite 350 - Memphis, TN 38128
Sutherland Cardiology & Methodist Germantown Diagnostic Group (DBA: Sutherland Cardiology Clinic & Cardiovascular Outpatient Diagnostic Center) - 7460 Wolf River Boulevard - Germantown, TN 38138
Methodist Diagnostic Center – Germantown - 1377 South Germantown Road – Germantown, TN 38183
Le Bonheur Outpatient Rehab - 980 Poplar Avenue – Memphis, TN 38103
Le Bonheur Urgent Care - Hacks Cross - 8071 Winchester Road Suite 2 – Memphis, TN 38125
Methodist Healthcare Outpatient Services (DBA: West Cancer Center) - 240 Grandview Drive – Brighton, TN 38011
Methodist Healthcare Outpatient Services & Methodist Mobile Mammography (DBA: West Cancer Center) - 7945 Wolf River Boulevard – Germantown, TN 38011
Methodist Healthcare Outpatient Services (DBA: West Cancer Center) - 1588 Union Avenue – Memphis, TN 38104

Methodist Healthcare Outpatient Services (DBA: West Cancer Center) - 7668 Airways Blvd – Southaven, MS 38671
Methodist Healthcare Outpatient Services (DBA: Margaret West Screening Breast Center) - 1381 S. Germantown Rd – Germantown, TN 38183
Methodist Sleep Disorders Center - 5050 Poplar Avenue Suite 300 – Memphis, TN 38157
Methodist Medical Group (DBA: Arthritis Group) - 1211 Union Avenue – Suite 200 – Memphis, TN 38104
Methodist Medical Group (DBA: Bartlett Internal Medicine) - 6570 Summer Oaks Cove – Bartlett, TN 38134
Methodist Medical Group (DBA: Comprehensive Primary Care) – 76 Capital Way #C – Atoka, TN 38004
Methodist Medical Group (DBA: Covington Pike Medical) - 3789 Covington Pike – Bartlett, TN 38135
Methodist Medical Group (DBA: Eastmoreland Internal Medicine) - 1325 Eastmoreland #245 – Memphis, TN 38104
Methodist Medical Group (DBA: Endocrinology Clinic) - 6401 Poplar Avenue Suite 400 – Memphis, TN 38119
Methodist Medical Group (DBA: Foundation Medical Group) - 7690 Wolf River Circle – Germantown, TN 38138
Methodist Medical Group (DBA: Germantown Internal Medicine Associates) - 7796 Wolf Trail Cove #201 – Germantown, TN 38138
Methodist Medical Group (DBA: Methodist Medical Group -Highland) - 3473 Poplar Avenue #103 – Memphis, TN 38111
Methodist Medical Group (DBA: Kraus Internal Medicine) - 7550 Wolf River Boulevard #103 – Germantown, TN 38138
Methodist Medical Group (DBA: Lakeland Family Medicine) - 2961 Canada Road #105 – Lakeland, TN 38002
Methodist Medical Group (DBA: MidSouth Family Medicine--Bartlett) - 2589 Appling Road #101 – Bartlett, TN 38133
Methodist Medical Group (DBA: MidSouth Family Medicine--Country Village) - 8115 Country Village – Cordova, TN 38016
Methodist Medical Group (DBA: MidSouth Family Medicine--Stonecreek) - 9047 Poplar Avenue #105 – Germantown, TN 38138
Methodist Medical Group (DBA: Midtown Internal Medicine) - 1533 Union Avenue – Memphis, TN 38104
Methodist Medical Group (DBA: Motley Internal Medicine Group) - 1264 Wesley Drive #606 – Memphis, TN 38116
Methodist Medical Group (DBA: Peabody Family Care) - 1325 Eastmoreland #150 – Memphis, TN 38104
Methodist Medical Group (DBA: PennMarc Internal Medicine) - 6401 Poplar Avenue #400 – Memphis, TN 38119
Methodist Medical Group (DBA: Southwind Medical Specialists--Sanderlin) - 5182 Sanderlin #3 – Memphis, TN 38117
Sutherland Cardiology (DBA: Sutherland Cardiology Clinic--North) - 3950 New Covington Pike Suite 220 – Memphis, TN 38117
Methodist Medical Group (DBA: The Internal Medicine Clinic) - 3950 New Covington Pike #110 – Memphis, TN 38104
UT Methodist Physicians (DBA: UTMP Surgical Oncology) - 1211 Union Avenue Suite 300 – Memphis, TN 38104
UT Methodist Physicians (DBA: UTMP Surgical Oncology) - 7945 Wolf River Boulevard Suite 280 – Germantown, TN 38138
UT Methodist Physicians (DBA: UTMP Multidisciplinary Clinic) - 57 Germantown Court #100 – Memphis, TN 38018

UT Methodist Physicians (DBA: UTMP Multidisciplinary Clinic) - 1251 Wesley Drive Suite 151 – Memphis, TN 38116
UT Methodist Physicians (DBA: UTMP Multidisciplinary Clinic) - 1325 Eastmoreland Suite 370 – Memphis, TN 38104
Methodist Healthcare Outpatient Services (DBA: West Cancer Center) - 1936 W. Poplar Ave. – Collierville, TN 38017
Methodist University Specialty Clinic & Sickle Cell Clinic - 1325 Eastmoreland Suite 101 – Memphis, TN 38104
Methodist Le Bonheur Healthcare Germantown Hospital Rehab and Outpatient Cardiac Rehab - 6560 Poplar Avenue – Memphis, TN 38138
Le Bonheur Outpatient Center - 51 N. Dunlap – Memphis, TN 38105
Le Bonheur Outpatient Center East - 100 North Humphreys Blvd. – Memphis, TN 38120
Methodist Medical Group (DBA: Brighton Family Medicine) - 1880 Old Hwy. 51 S. #C – Brighton, TN 38011
Methodist Healthcare Outpatient Services (DBA: West Cancer Center) - 1211 Union Suite 400 – Memphis, TN 38104
UT Methodist Physicians (DBA: UTMP Cardiology) - 1211 Union Avenue #965 – Memphis, TN 38104
UT Methodist Physicians (DBA: UTMP Cardiology) - 1251 Wesley Drive Suite 153 – Memphis, TN 38116

This accreditation requires an annual survey and the organization's continual compliance with the DNVHC Accreditation Process. Failure to complete these actions or otherwise comply with your Management System Certification/Accreditation Agreement may result in a change in your organization's accreditation status.

Congratulations on this significant achievement.

Sincerely,

Patrick Horine
Chief Executive Officer
cc: CMS CO and CMS RO IV (Atlanta)

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
215075-2017-AHC-USA-NIAHO	2/27/2017	2/27/2020

This is to certify that:

Methodist Healthcare – Memphis Hospitals

1265 Union Avenue, Memphis, TN 38104

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

C: Orderly Development D2

CMS Letter of Compliance

MMetodist ComplianceDepartment of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF CLINICAL STANDARDS & QUALITY

Ref S Methedist 44-0049

Important Notice – Please Read Carefully

April 8, 2016

Mr.Michael Ugwueke, Administrattor
Methodist Healthcare Memphis Hospitals
1265 Union Ave Suite 700
Memphis, TN 38104

RE: CCN 34-1322

Dear Mr. Ugwueke

Based on the acceptable Plan of Correction and findings at a follow-up survey ending on April,5, 2016. it has been determined that your hospital is now in full compliance with the Medicare Conditions of Participation. There were no deficiencies cited. We are rescinding the termination action of the March 7, 2016, and the amended letter., restoring your hospital's deemed status and removing it from State monitoring. Methodist Healthcare Memphis Hospitals will continue as a provider of services under the Medicare program.

We have notified all appropriate parties of this action. If you have any questions or concerns, please contact Rosemary L. Robinson at (404) 562-7405.

Sincerely,

for Rosemary L. Robinson

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

CC: State Agency
JC

C: Proof of Publication

Proof of Publication

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Legal Notices

Legal Notices

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Methodist Healthcare - Memphis Hospitals dba Methodist North Hospital (a general hospital, owned and managed by Methodist Healthcare - Memphis Hospitals (a not for profit corporation), intends to file an application for a Certificate of Need for the relocation of 34 licensed adult psychiatric beds. The beds are currently located at 1265 Union Avenue, Memphis, TN 38104 on the Methodist University Hospital campus. Methodist Healthcare - Memphis Hospitals proposes to move them to 3960 New Covington Pike, Memphis, TN 38128 on the Methodist North Hospital campus. Both hospitals are operated under the Methodist Healthcare - Memphis Hospitals license and total licensed beds for the System will not change. There will be renovation of 18,976 square feet of space to accommodate the relocated psychiatric beds and services. The project does not contain any major medical equipment or initiate or discontinue any health service and it will not affect any other licensed bed complements. The estimated project cost is $2,285,000

The anticipated date of filing the application is on or before September 15, 2017. The contact person for this project is Carol Weidenhoffer, Senior Director of Planning and Business Development, who may be reached at: Methodist Le Bonheur Healthcare, 1211 Union Avenue, Suite 365, Memphis, TN, 38104, 901-516-0979.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1), (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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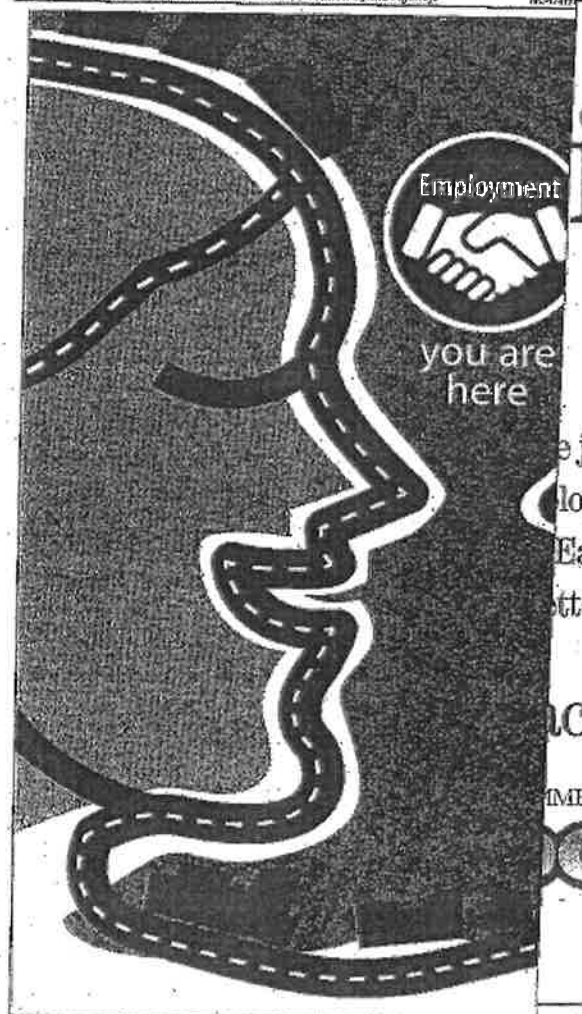

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Alliance Healthcare Services

September 22, 2017

Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
502 Deaderick Street – 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

I am writing this letter to pledge strong support for Methodist Healthcare – Memphis Hospitals Certificate of Need to relocate their 34-bed inpatient psychiatric unit to the Methodist North Hospital. I am the CEO of Alliance Healthcare Services which is the largest comprehensive mental health provider in Shelby County offering outpatient services, the mobile crisis unit, crisis stabilization services, medically managed detox services and respite care. Alliance Healthcare has been the behavioral health consultation liaison for Methodist Le Bonheur Healthcare for _7_ years. Alliance Healthcare Services supports Methodist's commitment to continue to provide psychiatric services in the new location at Methodist North Hospital.

Alliance Healthcare Services operates crisis services for mental health disorders in the Shelby County services area, and Methodist is an essential inpatient provider in the regional adult care continuum. Many of the chronic mental health patients who are initially treated through Alliance Healthcare's crisis services are admitted to the inpatient unit at Methodist. The inpatient unit treats a significant number of our mentally disabled patients in need of acute medical needs. The unit provides the stabilizing medical-surgical care and psychiatric services needed for this population through high quality assessments, evidenced-based therapeutic interventions and timely discharge with coordinated care to other providers in the community.

Methodist is a long-term partner in the health care needs of the mentally disabled in the local community, and we support the relocation of their program. The new location at Methodist North will expand the space allocated for the behavioral health service line, improve security and privacy for admissions to the unit and sustain a needed resource in the Shelby County community. We appreciate your consideration and request approval of this application.

Sincerely,

Gene Lawrence
CEO, Alliance Healthcare Services

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

SEP 26 2017 108

September 22, 2017

Melanie Hill, Executive Director
State of Tennessee
Health Services and Development Agency
502 Deaderick Street – 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Please accept this letter as support for Methodist Healthcare – Memphis Hospitals' Certificate of Need to relocate their 34-bed inpatient psychiatric unit from the Methodist University campus to Methodist North. I am the CEO of Lakeside Behavioral Health System which has been a premier provider of specialized behavioral health care and addiction services in the Mid-South since 1969. Lakeside operates the largest freestanding facility in the region on a 37-acre campus on the outskirts of Memphis in Shelby County, Tennessee. Our comprehensive behavioral health services include inpatient, intensive outpatient, partial hospitalization and residential treatments for all ages. Lakeside fully supports Methodist's continued commitment to inpatient psychiatric services and the planned relocation to the Methodist North Hospital.

Methodist is an important contributor in the behavioral health continuum of care and a solid partner through their long-term commitment to treat the severely and persistently mentally ill population. The psychiatric inpatient unit at Methodist has been opened for over 40 years and at one time was managed by Lakeside Behavioral Health System. While Lakeside accepts referrals from all healthcare providers in the service area, this historical connection is the basis for strong referral patterns between the two entities and effective coordination of care for shared patients. The inpatient services will be enhanced in the new location on the Methodist North campus with added space for existing services and improved secured, controlled access with the separate, yet adjoining building adjacent to general hospital services. The relocation of the psychiatric unit reaffirms Methodist's commitment to the provision of behavioral health services at Methodist North Hospital.

We support Methodist in their request to relocate existing psychiatric services, and request your consideration and approval of the application.

Sincerely,

Joy Golden

Joy Golden
Chief Executive Officer
Lakeside Behavioral Health System

Supplemental #1
(COPY)

Methodist Healthcare-Memphis Hospitals dba Methodist North Hospital

CN1709-029

METHODIST HEALTHCARE—
MEMPHIS HOSPITALS

SUPPLEMENTAL RESPONSE
CN1709-029

METHODIST NORTH HOSPITAL
PSYCHIATRIC UNIT
RELOCATION

MEMPHIS, SHELBY COUNTY

Filed September 2017

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF SHELBY

NAME OF FACILITY: METHODIST HEALTHCARE – MEMPHIS HOSPITALS, DBA METHODIST NORTH HOSPITAL

I, FLORENCE JONES, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Florence Jones, President
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 25 day of September, 2017, witness my hand at office in the County of Shelby, State of Tennessee.

Nancy Slone
NOTARY PUBLIC

My commission expires My Commission Expires January 20, 2019.

NANCY SLONE STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

HF-0043

Revised 7/02

1. **Section A. Executive Summary, A. Overview, Description (1) Page 2**

   The applicant notes the project will add 34 licensed beds equaling 11 private and 22 semi-private beds to the Methodist North campus. However, the private and semi-private beds total 33, not 34. Please clarify.

   Please see corrected page 2 in Attachment A. This is a typo. This application is for 10 private and 24 semi-private beds totaling 34 psychiatric beds. Please see Attachment A:6B-2 for the Floor Plans submitted with the original application for the configuration and attached again for reference as part of Attachment A.

   Please indicate the number of semi-private and private rooms at the current 34 bed psychiatric unit.

   The current unit on the Methodist University campus has the same mix of private and semi-private beds with 10 private and 24 semi-private. This is a relocation of all existing services as currently configured.

   Where were the psych beds proposed to relocate in CN1602-009? How will that space be utilized now?

   Methodist originally planned to relocate the 34-bed psychiatric unit to twelfth and thirteenth floors in the Thomas building on the Methodist University campus as documented in CN1602-009. As noted throughout this application, the location on the Methodist North campus is a better footprint for the psychiatric environment of care. The space on the Methodist University campus will be converted into administrative offices and expansion of research space. As noted in CN1602-009, the older buildings on the Methodist University campus present challenges to the patient experience and the patient and family approach to care. The Thomas wing was originally built in 1966 and recent plans propose to repurpose the building for non-clinical departments.

2. **Section A. Executive Summary, A. Overview, Project Cost (5) Page 3**

   The applicant notes the estimated project cost is $2,292,551. However, the Project Cost Chart lists the cost as $2,295,000. Please clarify.

   Please see corrected page 3 in Attachment B. This is a typo. The correct total Project Cost is $2,295,000.

3. **Section A. Executive Summary, B. Rationale for Approval, (1) Need Page 4**

The applicant references the Crisis Assessment Center. Please describe the Crisis Assessment Center and what entity operates it.

The Crisis Assessment Center is operated by Alliance Healthcare Services. The Crisis Center provides a 24/7 crisis intervention hotline and referral, including mobile crisis assessment services, crisis respite services and crisis stabilization services. The Crisis Center provides pre-screening for mental health services, mobile crisis team and emergency outpatient clinic for residents of Shelby County ages 18 and over. Please see Attachment C for a statewide map of Crisis Services posted by the Tennessee Department of Mental Health and Substance Abuse Services.

Also see a Letter of Support from Alliance Healthcare Services in Attachment G.

Since the majority of the patients served are under Age 65, please explain in more detail how SPMI patients who are psychiatrically disabled adults qualify for Medicare.

Medicare is available for certain people with disabilities who are under age 65. Medicare coverage and full benefits are the same for people who qualify based on disability as well as those who qualify based on their age. Coverage includes any hospital, nursing home, home health, physician and community-based services. People with dementia, mental illness, and other long term and chronic conditions are covered under Medicare not by age, but by disability. SPMI is considered to be a mental health disability and is covered under Medicare.

4. **Section A. Executive Summary, B. Rationale for Approval, (2) Economic Feasibility, Page 4**

The applicant notes the proposed beds will be licensed by the DNV. What does the acronym DNV represent?

DNV stands for Det Norske Veritas. Please see the description below from their website (http://dnvglhealthcare.com/accreditations/hospital-accreditation).

"The requirements of the DNV GL - International Healthcare Accreditation are based upon those in our NIAHO® standards that have been approved by the US Government's Centers for Medicare and Medicaid (CMS).The International requirements have been adapted so as to have applicability

internationally, with sensitivity to local laws, practices and regulations, and have been accredited by ISQua. Our approach integrates proven quality and risk management principles with specific clinical and physical environment requirements."

5. **Section A, Project Details, Item 10 Bed Complement Data Page 9**

With respect to the design of the patient rooms, what is the AIA recommended patient room size for the psychiatric unit and how does it compare to room size at the existing hospital and the proposed site?

The 2010 edition of Guidelines for Design and Construction of Healthcare Facilities 2.5-2.2.2.2 currently enforced by State of Tennessee states:

"(1) Patient rooms shall have a minimum clear floor area of 100 square feet (9.29 square meters) for single bed rooms and 80 square feet (7.43 square meters) per bed for multiple-bed rooms."

The room sizes at Methodist University and those proposed at Methodist North exceed these minimum guidelines.

The rooms currently in operation at Methodist University are 171 square feet (sf) for private rooms (single bed) and 209 sf per room (or approximately 105 sf per bed) for semi-private.

Much of the room configuration in the proposed building at Methodist North was kept intact to control renovation cost, therefore, there are two proposed room sizes for private rooms. Seven private rooms are 149 sf and three private rooms are 227 sf. The smaller private rooms are still 1.5 times the recommended floor area. The semi-private rooms are 227 sf per room (or approximately 114 sf per bed). The room sizes meet and exceed the recommendations.

Please indicate what the biomed (647 SF) and classroom (878 SF) renovation relates to the proposed project.

The biomed and classroom relocations and renovations are part of the project to col-locate the psychiatric administrative offices with the patient care area and ensure patient security and privacy. The classroom space is currently located in the area being renovated for the psychiatric unit. The classroom will be relocated (as noted in the floor plans filed with application and also Attachment A in this response) outside the patient care area to allow the area to be adjacent to the behavioral health unit. The classroom will move to the existing biomed location to minimize crossing of

public/staff circulation with the behavioral health patients' circulation from the dedicated entry. Biomed will be located off the corridor to the unit.

According to the 2015 JAR, Methodist North operated at 61.9%. With 246 licensed beds that would mean on average there are 93 empty beds in the hospital. Please explain why the 34 psych. beds could not be absorbed into the existing licensed bed complement without adding licensed beds to the hospital.

The 2015 occupancy percentage calculated above does not include effective patient in-bed days. The calculation from the Joint Annual Report (JAR) shows that Methodist North operated at 61.9% of licensed beds. This calculation uses 55,560 inpatient bed days only.

Inpatient beds are also occupied by observation patients (5,592 observation days) and patients for partial days during admission or discharge processes (10,688 discharges). Depending on time of day patients arrive and time of day they depart, they are effectively using more than the counted patient days. Actual effective patient in-bed days are higher. The effective patient in-bed days are 71,840 (55,560 + 5,592 + 10,688) or 80% occupancy of licensed beds.

In addition to patients in the bed, there are additional factors that constrain capacity such as bed turnover, room cleaning and room repairs which take beds out of service for part of all of a day. Factoring in additional bed turnover raises the effective occupancy for the licensed beds at North to 85% and over 90% for staffed beds.

The higher effective occupancy rates presented above are annual averages which also do not account for seasonal spikes during busy flu and respiratory periods or busier days of the week for scheduled surgeries and procedures. Methodist does not think it is operationally prudent to absorb the 34-bed psych unit into the existing 246 licensed beds at Methodist North. Methodist proposes to maintain the total 246 licensed beds for the existing patient complement, and add the 34 transferred licensed beds for the mental health patients. As noted previously in the application, this does not add beds to the market or change the total Methodist Healthcare – Memphis Hospital license.

6. **Section B. Need, Item 1 (Project Specific Criteria)**

Please address questions 2 (a) and 2 (b) of the criteria for the Construction, Renovation, Expansion, and Replacement of Health Care Institutions.

Construction, Renovation, Expansion, and Replacement of Health Care Institutions:

2. For the relocation or replacement of an existing licensed health care institution:

a) **The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weakness of each alternative.**

b) **The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**

The applicant is presenting justification for relocation a) and b) in this response.

Currently, Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. The demolition of the Crews building – where the psychiatric unit is housed – will force the relocation of the program and beds. With the approval and plans for the University campus, there is not a renovation option where the beds are housed in the Crew wing.

Methodist is committed to maintaining psychiatric inpatient services for the community, new locations were considered. The possibilities were narrowed to the Methodist University campus in Thomas Wing, and the Methodist North campus. This project was the more cost effective location and less disruptive option for the relocation. The proposed location is attached to the main hospital but contained as singular space; it has a covered entrance and close parking. The building is isolated from the rest of the general hospital with a separate entrance. The secured, controlled access makes it an optimal setting for psychiatric services to ensure privacy and

The choice to relocate the 34 beds to a hospital within the same system, only 13.7 miles away, allows Methodist to serve the same community with the same resources. The full program including equipment, staff, and physicians will be relocated simultaneously.

The majority of patients admitted to the Methodist psychiatric unit are SPMI patients who are psychiatrically disabled adults with

Medicare coverage. Methodist will continue to serve chronic, SPMI patients in this unit with onsite acute medical services to treat comorbid medical conditions. Projections show the composition of the population and mix of populations served will not change.

Methodist Healthcare-Memphis Hospitals Psychiatry Utilization and Occupancy					
	2014	**2015**	**2016**	**2020**	**2021**
Discharges	441	388	370	337	375
Days	8467	7791	7336	6640	7388
Average Daily Census	23.20	21.35	20.04	18.19	20.24
Occupancy Rate	68%	63%	59%	54%	60%

Methodist currently plays an active role in the psychiatric continuum of care in the service area with positive relationships with referral sources. The majority of the applicant's patients arrive during crisis by ambulance or as direct referrals from the Crisis Assessment Center. This relocation maintains positive referral relationships in an improved location.

7. **Section B, Need, Item C, Page 20**

The Historical and Projected utilization by county residents are noted. However, it appears the two tables total 371 and 337, respectively. Please clarify.

In the charts filed with the original application, there was a typo for the Other States line which created an additional rounding error in the Projected Year. Please see charts below which are corrected for this rounding. The original charts showed correct total patients served in 2016 as 370 and Projected Year 1 (2020) as 337.

	Historical (2016) Utilization- County Residents	**Historical (2016) % of total**	**Projected (Year 1-2020) Utilization- County Residents**	**Projected (Year 1) % of total**
Shelby County	313	85%	285	85%
Other TN Counties	24	6%	22	6%
Other AR Counties	14	4%	13	4%
Other MS Counties	11	3%	10	3%
Other States	8	2%	7	2%
Total	370	100%	337	100%

8. **Section B, Need, Item D (`1)**

The demographic variable/geographic area table is noted. However, please revise the table to reflect the years 2017 and 2021 and submit a revised page.

Please see Attachment D for the revised (renumbered to page 26 as noted below) with the demographic / geographic area table.

The page that contains the demographic variable/geographic area table is labeled as page 12. It appears the application has several duplicative page numbers and is not numbered in order. Please clarify.

Please see Attachment E which includes the full reprinted original application with attachments. The applicant copied the template from the HSDA website, but must have reset page numbers with insertions and formatting before printing. The duplicative page numbers have been corrected. The revised pages attached for other supplemental responses have been inserted in this copy as well for convenience and denoted with an 'R'.

Please clarify the target population age range.

The applicant's target population includes ages 18 years of age and up due to the SPMI disabled population plus the Medicare population served currently. There is no projected change in the patient population served.

9. **Section B, Need, Item F**

Patient days at the psychiatric unit declined from 8,467 in 2014 to 7,336 in 2016, or 13.4% or an average annual decrease of 6.7%. With that historical decline please explain why the applicant's unit will not expect to experience this level of decline in the future years versus its projection of being back at 2016 levels by 2021.

Methodist currently plays an active role in the psychiatric continuum of care in the service area with positive relationships with referral sources. The majority of the applicant's patients arrive during crisis by ambulance or as direct referrals from the Crisis Assessment Center. This relocation maintains positive referral relationships in an improved location.

Additional, forecast models provided by external vendor for the Shelby County psychiatric inpatient market were used to validate overall market volumes used in assumptions for projections. Psychiatric days are projected in the vendor supplied model to increase by 8% over the five year

period (2016-21). Methodist projects no change in market share.

Methodist's knowledge of their role in the market and the projections validated by external sources led planners to project a stabilization of inpatient volumes in year 2 of the project.

Methodist Healthcare-Memphis Hospitals Psychiatry Utilization and Occupancy					
	2014	2015	2016	2020	2021
Discharges	441	388	370	337	375
Days	8467	7791	7336	6640	7388
Average Daily Census	23.20	21.35	20.04	18.19	20.24
Occupancy Rate	68%	63%	59%	54%	60%

10. **Section B., Economic Feasibility Item C. (Historical Data Chart)**

Historical Data Chart (Project Only) - The Year 2016 net income of $484 on page 2 of the Historical Data Chart (project only) is noted. However, it appears the amount listed should be ($484). Please clarify.

Please see corrected page 34 (renumbered as previously noted) in Attachment F. This is a typo.

11. **Section B., Economic Feasibility Item F. (3) Capitalization Ratio**

It is noted the Capitalization Ratio for MLH 2016 audited financial statement is 0.26. Please provide an explanation how this figure was computed using the formula in the application.

The formula for the Capitalization Ratio applied to Methodist Le Bonheur Healthcare 2016 Audited Financial States is below. The decimal place was incorrectly reported in the original application.

(Long-term debt / (Long-term debt + Total Equity (Net assets)) x 100).
($507,432,000 / ($507,432,000 + $1,442,854,000) X 100) = 26

12. **Section B., Economic Feasibility Item H. Staffing Page 28**

Please explain why the projected staffing for the relocated unit is expected to decline from current levels.

As noted in the original application, Methodist staffs on a flexible staffing model based on the psychiatric unit's census. Year 1 projections as stated in the originally filed application and shown below for convenience reflect a slight disruption in service due to the relocation of the unit. Year 2 volumes stabilize and there is no expected decline in staffing with continued volumes.

Methodist Healthcare-Memphis Hospitals Psychiatry Utilization and Occupancy						
	2014	2015	2016		2020	2021
Discharges	441	388	370		337	375
Days	8467	7791	7336		6640	7388
Average Daily Census	23.20	21.35	20.04		18.19	20.24
Occupancy Rate	68%	63%	59%		54%	60%

Assumptions for Year 1

- **10% Utilization reduction in Year 1 due to slight disruption relocating unit.**

Assumptions for Year 2

- **11% Utilization rebound in Year 2 as services stabilize and continue existing referral patterns and admission processes.**

13. **Section B: Contribution to the Orderly Development of Health Care, Section B: Quality Measures, Section C: State Health Plan Questions, Project Completion Forecast Chart**

It is noted the applicant only addressed Item A. in Section B: Contribution to the Orderly Development of Health Care and did not address the remaining sections of the application. Please totally address the following application sections numbering each page and submit:

- Section B: Contribution to the Orderly Development of Health Care
- Section B: Quality Measures
- State Health Plan Questions
- Project Completion Forecast Chart

Please see Attachment E which includes the full reprinted original application with attachments. The applicant copied the template from the HSDA website, but must have reset page numbers with insertions and formatting before printing. The page numbering error created printing errors for the final section of the application. The missing pages were

submitted in a supplemental response dated September 22, 2017. The pages are included in Attachment E.

14. Section B. Quality Measures

Please discuss the applicant's commitment to the proposal in meeting appropriate quality standards by addressing each of the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

The applicant commits to maintaining a payor mix that is comparable to projections in the application. This project is the relocation of existing service with well-established referral patterns and recognized role in the regional psychiatric care continuum. Methodist is committed to serving the same patient population in this new location.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

The applicant commits to maintaining staffing comparable to the staffing proposed in the application. As noted in the application, Methodist plans to relocate all staff with the beds. A flexible staffing model is currently used which is based on the unit's census. The same model will remain intact at the new location.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

The applicant will maintain all applicable state licenses in good standing.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

The applicant will maintain TennCare and Medicare certifications.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

As noted in the original application, in March 2016 we received a notice of 23-day termination proceedings related to inappropriate use of force by a security officer at Methodist North Hospital. The hospital's Plan of Correction was accepted by CMS, and the follow-up survey on 4/5/2016 determined we were in full compliance with the Medicare Conditions of Participation. Under the leadership of a newly appointed system director of Environmental Health & Security, the hospital instituted an ongoing QAPI program for the Security Department. In addition, policies and procedures, training and competency for security officers were standardized.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Not applicable. The applicant has maintained full accreditation for the last three years. Methodist recently switched from Joint Commission accreditation to DNV (Det Norske Veritas) accreditation.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Center for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor would be acceptable if applicable.

   The applicant is fully accredited by DNV. Methodist provides a quality improvement program that includes outcomes and process monitoring systems and currently reports all quality metrics to DNV. The DNV accreditation process is an annual review and assessment process.

(q) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

The applicant is in compliance with the appropriate rules of the TDH and the TDMHSAS for accommodations including two restraint beds available when and if needed. The restraint beds are in separate rooms and will continue to be monitored in a one to one patient to staff ratio.

Additionally, Methodist proposes a dedicated men's and women's wing to ensure appropriate accommodations by gender. The applicant does not discriminate against different cultures or populations of people. The applicant maintains that they have a multi-diverse staff that aligns with the community.

Methodist plans on relocating all staff with these beds and services to the proposed location. The clinical / direct patient care staff for this project is currently employed by Methodist with the staffing patterns as noted below. There will be no changes to staffing patterns with this project. Methodist utilizes flexible staffing model based on the psychiatric unit's census as shown below with 12-hour RN shifts.

Number of Nursing Personnel			
Shift	**RN**	**Aides**	**Other**
Day	5 (12 hour shift)	2	4
Evening	1	4	
Night	3 (12 hour shift)	1	

RN Duty Roster			
Shift	**SUN**	**MON - FRI**	**SAT**
Day (12 hour shift)	3	5	3
Evening		1	
Night (12 hour shift)	3	3	3

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; and

The applicant provides a quality improvement program that includes outcomes and process monitoring systems and currently reports all quality metrics to DNV. The applicant is engaged in reporting this data on an ongoing and regular basis.

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

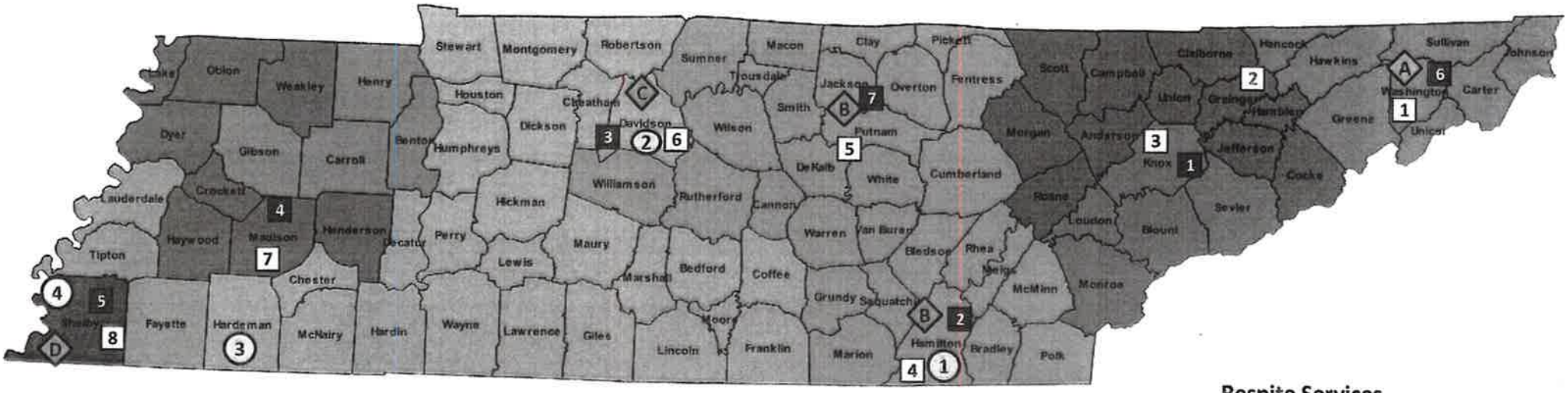
Not applicable. The applicant does not own or administer other psychiatric facilities.

Please see Applicant supplied Letters of Support from Alliance Healthcare Services and Lakeside Behavioral Health Systems in addition to the responses above as Attachment G. Please note these Letters of Support in the consideration of the Request for Consent Calendar.

ATTACHMENT C

Department of Mental Health & Substance Abuse Services

TENNESSEE CRISIS SERVICES STATEWIDE MAP



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Mobile Crisis Teams

- Frontier Health
- Cherokee Health Systems
- Ridgeview Psychiatric Hospital & Center
- Helen Ross McNabb
- Volunteer Behavioral Health
- Mental Health Cooperative
- Centerstone Community MHC
- Carey Counseling Center
- Quinco Community MHC
- Pathways of Tennessee
- Professional Care Services
- Alliance Healthcare Services

Crisis Stabilization Units/Walk-in Center

1. Frontier Health
2. Cherokee Health Systems
3. Helen Ross McNabb Center
4. Volunteer Behavioral Health Chattanooga
5. Volunteer Behavioral Health Cookeville
6. Mental Health Co-Operative
7. Pathways of Tennessee
8. Alliance Healthcare Services

Regional Mental Health Institutes

1. Moccasin Bend Mental Health Institute
2. Middle Tennessee Mental Health Institute
3. Western Mental Health Institute
4. Memphis Mental Health Institute

Respite Services

- A Frontier Health
- B Volunteer Behavioral Health
- C Mental Health Co-operative
- D Alliance Healthcare Services

Medically Monitored Withdrawal Management (Detox)

1. Helen Ross McNabb
2. CADAS
3. Buffalo Valley
4. Pathways
5. Alliance Healthcare Services
6. Frontier
7. Volunteer

ATTACHMENT D

Supplemental #2
(COPY)

Methodist Healthcare
Memphis Hospitals

CN1709-029

Methodist℠ Healthcare

September 27, 2017

Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Methodist Healthcare--Memphis Hospitals dba Methodist North Hospital filed CN1709-029 to relocate Methodist's psychiatric unit on September 15, 2017. Please see responses to the second set of Supplemental questions received September 26, 2017 including additional copies or previous cover letters and affidavits that can be pulled and filed with copies already sent.

Enclosed in triplicate is the supplemental response. Please let us know if you have any questions or need additional information.

Sincerely,

Carol Weidenhoffer

Carol Weidenhoffer
Senior Director of Planning and Business Development

cc: Byron Trauger

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF SHELBY

NAME OF FACILITY:
Methodist Healthcare – Memphis Hospitals dba Methodist North Hospital

I, FLORENCE JONES, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Florence Jones, President
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27 day of Sept, 2017 witness my hand at office in the County of Shelby, State of Tennessee.

Nancy Slone
NOTARY PUBLIC

My commission expires My Commission Expires January 20, 2019.

NANCY SLONE STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

HF-0043

Revised 7/02

METHODIST HEALTHCARE—MEMPHIS HOSPITALS

SUPPLEMENTAL RESPONSE #2
CN1709-029

METHODIST NORTH HOSPITAL PSYCHIATRIC UNIT RELOCATION

MEMPHIS, SHELBY COUNTY

Filed September 2017

1. **Affidavit and Cover Letter**

   In the filing of additional information by the applicant dated September 22, 2017 it is noted HSDA receive only one copy of the Methodist Healthcare cover letter and affidavit. Please provide two copies each of the letter and affidavit per agency rule.

   Please see Attachment A for additional copies of the cover letters and affidavits dated September 15, 2017 and submitted with the original application plus those submitted with the September 22, 2017 and September 25, 2017 supplemental responses. This was an oversight.

2. **Section B. , Orderly Development, Item D**

   The Department of Health license for Methodist Healthcare-Memphis Hospitals located at 1265 Union Avenue, Memphis, TN is noted in Attachment B: Orderly Development D. Please clarify if the license includes the proposed application site of 3960 New Covington Pike, Memphis, TN 38128.

   Please see Attachment B for the revised Methodist Healthcare - Memphis Hospitals' license effective through September 14, 2018 which was received earlier this week.

   The applicant, owner, and licensee, Methodist Healthcare-Memphis Hospitals, is a not-for-profit corporation that operates five Shelby County hospitals under a single license including the applicant, Methodist North Hospital. The license also includes Methodist University Hospital, Methodist South Hospital, Methodist Le Bonheur Germantown Hospital, and Le Bonheur Children's Hospital.

   It is noted the applicant is accredited by "DNV GL-Healthcare". Please briefly describe this type of accreditation and how it relates to this project.

   DNV GL-Healthcare is one of the CMS approved accreditation organizations for hospitals. This accrediting program focuses on compliance with the CMS Conditions of Participation and the International Standards Organization (ISO) criteria for Quality Management Systems (ISO 9001:2015). Methodist Healthcare - Memphis Hospitals (including Methodist North Hospital) has obtained CMS Hospital Medicare accreditation form DNV GL- Healthcare.

Please see Attachment C for a revision to page 4 in the originally filed application that modifies a response to describe DNV as Methodist's accrediting organization.

3. **Section B. , Orderly Development, Item D (2) Page 47**

   Please provide a copy of the original survey and the hospital's plan of correction that is referenced in the April 8, 2016 letter from CMS in attachment "C: Orderly Development D2".

   Please see Attachment D for the Statement of Deficiencies and Plan of Correction related to the April 8, 2016 letter from CMS. The April letter from CMS is in attachments with the original filed application as C: Orderly Development D2 – CMS Letter of Compliance

4. **Section B. , Orderly Development, Item E (2) (G)**

   Please verify if Methodist Le Bonheur Healthcare System is involved in a class action lawsuit filed involving allegations of illegal billing practices.

   Methodist Le Bonheur Healthcare, parent company of the applicant, is involved in only one class action lawsuit involving allegations of illegal billing practices. This lawsuit was originally filed in 2009 and dismissed without prejudice by a federal court in 2011. It was refiled in 2013 in Shelby County Chancery Court. It was removed to federal court in July 2017 and because we believe the case to be without merit, we have filed a Motion to Dismiss which is pending now.

ATTACHMENT D

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440049	A. BUILDING _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HEALTHCARE MEMPHIS HOSPITALS	1265 UNION AVE SUITE 700 MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Intakes: TN00038091 A certification complaint survey was conducted from 2/22/16 to 2/29/16. An entrance conference was conducted on 2/22/16 at 9:40 AM with the Administrative Director, Quality and Performance Improvement and Regulatory Manager. A telephone exit conference was conducted on 3/1/16 at 8:00 AM with the Director of Qualtiy and System Regulatory, Director of Safety, Chief Quality Officer, Director of Quality, Patient Advocate, Chief Operating Officer, Regulatory Program Manager, Security Director, Emergency Department Director and Chief Nursing Officer. The hospital was informed of the IMMEDIATE JEOPARDY. Based on review of hospital policies, document review, medical record review, facility video footage and interviews, the hospital was found out of compliance with the following Conditions of Participation: 482.12 Governing Body, 482.13 Patient Rights and 482.21 QAPI. The hospital's failure to provide care in a safe setting, ensure freedom from abuse, and ensure an ongoing QAPI program resulted in a SERIOUS and IMMEDIATE THREAT to the health and safety of all patients receiving hospital services and placed them in IMMEDIATE JEOPARDY and at risk for serious injuries and/or death.	A 000	Immediate action was taken by the CEO and Chief Quality Officer to confirm the hospital provides care in a safe setting. Following the exit conference on 3/1/16 a Task Committee was established by the Director of Quality and System Regulatory and included the CEOs, Chief Quality Officer, Vice Presidents and Directors responsible for Security Officers, Director of Safety, Emergency Management and Security, Director Regulatory, Human Resource Directors, Director of Security and Assistant General Counsel. The Task Committee reviewed (1) relevant policies and procedures; (2) training and competencies; and (3) the QAPI program for Security Officers as noted for the individual TAGs below. Notification of Board and Senior Leadership: The Methodist Le Bonheur Healthcare Board of Directors - Executive Committee was notified regarding the CMS 2567, the immediate actions, and the plan for improvement on 3/10/16 via email sent by the CEO. Additionally, the Strategy Committee, including the CEOs of each hospital site, was informed of the State Agency findings and the plan for improvement by the CEO and Chief Quality Officer in their meeting on 3/4/16. (See Appendix B - Notifications)	3/2/16 3/10/16
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital.	A 043	Governing Body Oversight: **Review of Policies and Procedures:** The Vice President of Legal Service and Chief Quality Officer reviewed the current Charter to confirm the Board's oversight of the	3/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] MD
TITLE: Sr VP Chief Quality & Safety Officer
(X6) DATE: 3/29/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440049	A. BUILDING _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HEALTHCARE MEMPHIS-HOSPITALS	1265 UNION AVE SUITE 700 MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 1 If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on policy review, document review and interview, the Governing Body failed to assume responsibility and provide oversight of the hospital's quality of care, patient rights, QAPI program. The failure of the Governing Body to assume responsibility and provide oversight to ensure patients were kept safe and protected during emergency treatment resulted in a fractured arm for one of one (Patient #1) patients and placed all vulnerable patients at risk for SERIOUS INJURY resulting in IMMEDIATE JEOPARDY. Additionally, the Governing Body's failure to respond to assure appropriate training was instituted to secure a safe setting for provision of care demonstrates the IMMEDIATE THREAT TO THE HEALTH AND SAFETY of patients ongoing. The findings included: 1. The Governing Body failed to ensure the Chief Executive Officer (CEO) was responsible and ensured the safety of the patients in the hospital. Refer to A 057. 2. The Governing Body failed to ensure policies were implemented, all patients received appropriate care and services in a safe setting, were protected at all times, and their patient rights, dignity, and well-being were preserved.	A043	Continued From page 1 hospital's quality of care, patient rights, and QAPI program is clearly delineated and found the Charter to be clear and in compliance with 42 C.F.R. § 482.12. Specifically, the Charter states the Board Quality Committee is delegated full authority with respect to the following matters: " (a) overseeing the review and recommendations of appropriate plans for provision of care, quality assessment and performance improvement (QAPI), utilization management and patient safety throughout the Organization, including quality and safety issues specific to the populations served; (b) overseeing the review and recommendations concerning actions to be taken to assist all facilities to conform, as fully and completely as possible with all requirements of The Joint Commission, CMS, and any other regulatory, licensing or accrediting agencies; and...(f) Reviewing and acting on recommendations for approval of medically -related policies and recommendations developed by medical staff -led committees as well as system and hospital safety committees." (See Appendix C - Board Quality Committee Charter). **Monitoring:** A system director over the Security Departments was appointed by the CEO on 3/8/16. This new system leadership role reports directly to the Sr. VP Clinical Effectiveness/Chief Quality Officer and will have responsibility for monitoring the work practices, security events, and QAPI program related to Security Officers system-wide.	3/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440049	A. BUILDING _____ B. WING _____	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HEALTHCARE MEMPHIS HOSPITALS	1265 UNION AVE SUITE 700 MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 2 Refer to A 0115, A 0144 and A 0145. 3. The Governing Body failed to ensure the Quality Assessment Performance Improvement (QAPI) committee analyzed and reviewed all adverse patient events and implemented preventative actions to ensure the events did not reoccur. Refer to A 0263 and A 0286.	A 043	Continue From page 2 Security physical intervention events will be reviewed by the new system Director of Safety, Emergency Management, and Security and facility Security Directors to ensure appropriate level of assessment and intervention by Security Officers. The above Directors will report and review the events at the system Environment of Care (EOC) Security Subcommittee and EOC Committee	
A 057	482.12(b) CHIEF EXECUTIVE OFFICER The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on facility document review, policy review, record review, observation and interview, the Chief Executive Officer (CEO) failed to be responsible for the management of the hospital, ensure staff provided care to vulnerable patients in a safe environment and patients rights were promoted for 1 of 1 (Patient #1) sampled patients whose rights were violated resulting in a fractured arm. The findings included: 1. Review of the Safety Operations Committee meeting minutes for 1/14/16 documented a reportable adverse event occurred on 3/21/15 in which baton use by a security officer did not align with facility policy and procedure. Crisis Prevention Intervention (CPI) training was to be completed by 5/5/15. There was no documentation that the CPI training had been completed by 5/15/15. The only Security specific training required of the officers was the continued	A 057	and the frequency of reporting will increase from bimonthly to monthly, as part of their ongoing QAPI program. A summary report will be provided by the Director of Safety, Emergency Management and Security at each system Safety Operations Council (SOC) meeting on monthly basis/10-months per year. The system SOC will oversee any improvement cycles. The Board Quality Committee will review Minutes from each system SOC meeting, and will receive and review a summary of these events, quarterly for 24 months. The effectiveness of the QAPI program will be reviewed annually by the Board Quality Committee, which will review trends for indicators related to the number of security events, appropriateness of de-escalation or use of physical tactics, harm events, completion of causal analysis, performance improvement, and required reporting to the facility and system QAPI committees. Additionally, the Board Quality Committee Chair will provide a summary of the Quality Committee information at full Board meetings (quarterly).	

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A 057	Continued From page 3 use of the basic baton and aerosol training. 2. Review of an email dated 2/25/16 from the Chief Operating Officer revealed "...Prior to... [December 2015] the only Security specific training required for our officers was the basic baton and basic aerosol training..." 3. Review of 2/25/16 at 5:55 PM email from the Chief Operating Officer to the surveyor revealed training cards for Security Officers #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17 and 18 for completed training and certification for basic baton training and basic aerosol training with no completion date. Review of basic aerosol training materials revealed the following facts about aerosols: The aerosols effect the eyes, face, respiratory system and skin pigmentation. The physical actions include rigid muscles, auditory exclusions, tunnel vision, basic fear, blindness and suffocation. Review of basic baton training materials revealed the following about baton usage: The use of a baton works on the motor nerves. Motor nerve points regulate the neural impulses that control the movement of muscles. When these signals are interrupted, there is a high intensity of pain, motor dysfunction/temporary paralysis of a particular muscle group, a sympathetic flexing response of the opposite unaffected joint. Refer to A 286. 2. A second reportable adverse event concerning a security officer occurred on 12/23/15. Review of the patient's medical record revealed Patient #1 was admitted to the Emergency Department	A 057	Continued From page 3 Chief Executive Officer: **Policies and Procedures Reviewed:** The Task Committee and the CEO reviewed, revised and approved the Security Policy: Use of Security Personnel to Deescalate and Resolve Threats to Safety on 3/28/16. The Policy ensures that crisis intervention and de-escalation techniques are used as the initial response and weapons are only deployed by Security Officers as a last resort in a situation involving an immediate physical threat to safety. The new policy states "use of weapons and security handcuffs is considered a law enforcement activity, not a health care intervention," and the perpetrator who is demonstrating criminal activity should be turned over to law enforcement. The policy further clarifies that "weapons or handcuffs should not be used to subdue a patient to apply a health care restraint/seclusion." (See Appendix C - Policy and Approvals) **Training:** The CEO at each hospital site was educated on the new policy and their role in the oversight of the Security Department and related QAPI activities via email communication from the Chief Quality Officer on 3/28/16. **Monitoring:** Beginning 3/1/16, each hospital site CEO and the system Director of Safety, Emergency Management, and Security will be responsible to ensure each physical intervention incident is reviewed by two Security Directors from another	3/28/16 3/28/16 3/30/16

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A 057	Continued From page 4 (ED) on 12/23/15 via ambulance after passing out from too many alcoholic beverages. The patient was triaged and medical care initiated including lab work which revealed a blood alcohol level of 374 (the reference range used by the facility was less than or equal to 3 was normal). According to nursing documentation the patient eventually became agitated and Security was called to the ED. The Security Officer grabbed the patients left wrist and the patient kicked out at the Security Officer. A loud "pop" was heard and the patient yelled his arm was broken. Review of the security officer's personnel file revealed the security officer had not received CPI training. As a result of the incident, Patient #1 sustained an oblique comminuted fracture of the distal shaft of the ulna. The patient's arm was splinted and he was discharged with orders for follow-up with an orthopedic physician. 3. There was no documentation the CEO had investigated the incident to determine the root cause in order to implement appropriate interventions and follow up to ensure patient's received care in a safe environment and were free of abuse. Refer to A 144, A 145 and A 286.	A 057	Continued From page 4 hospital site to determine if the degree of de-escalation or physical engagement is appropriate. All physical intervention events resulting in harm will be reviewed by the hospital site CEO or designee, Vice President and Security Director by the next weekly business day. The Security Director will provide a summary report to the hospital site QAPI committee. The hospital site CEOs and QAPI Committees will ensure a thorough common cause analysis is conducted on all events with harm and an ongoing QAPI program is in place to protect the health and safety of all patients. (See Appendix D - Compliance Monitoring)	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on document review, medical record review and interview, the facility failed to protect patients' rights in all areas of the hospital, to provide freedom from abuse and to provide care	A 115	<u>Actions to Protect Patients' Rights:</u> Immediately upon completion of the exit conference on 3/1/16 and receipt of the CMS 2567 on 3/8/16, action was taken to confirm the hospital continues to provide care in a safe setting, including – 1) Task Committee convened on 3/2/16;	3/28/16

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A 115	Continued From page 5 in a safe setting for all facility patients. Failure by the facility to provide freedom from abuse and care in a safe setting resulted in a SERIOUS AND IMMEDIATE THREAT for all facility patients. The findings included: 1. The facility failed to provide care in a safe setting for vulnerable patients presenting to the hospital Emergency Department. Refer to A 0144. 2. The facility failed to protect all patients from abuse. Refer to A 0145. 2. The facility failed to analyze contributing factors and implement measures in order to prevent patient abuse. Refer to A 0286	A 115	Continued From page 5 2) Security Officers without evidence of proper training were no longer provided equipment effective 0800 3/2/16; 3) Immediate training and competency test for Security officers competed by 3/10/16; 4) Board of Directors was notified and confirmation of their role in oversight by 3/10/16; 5) Facility CEOs notified and their role in oversight and management of the Security Department confirmed by 3/28/16; 6) Use of physical intervention and CPI training completed by all Security Officers by 3/18/16; 7) Initial and ongoing competencies for Security Officers developed and approved by 3/11/16; and 8) Enhanced QAPI program for Security physical intervention occurrences and patient safety confirmed and continuously in place by 3/18/16.	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETIING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of the Emergency Medical Services (EMS) report, policy review, medical record review, video recording review and interview, the hospital failed to ensure vulnerable patients received care in a safe manner for 1 of 1 (Patient #1) sampled patients who sustained injury while in the care of the hospital. Failure of the hospital to ensure patients were kept safe during emergency treatment resulted in a	A 144	**Policy Review and Revision:** The Task Committee and the CEO reviewed, revised and approved the Security Policy: Use of Security Personnel to Deescalate and Resolve Threats to Safety on 3/28/16. The Policy ensures that crisis intervention and de-escalation techniques are used as the initial response and weapons are only deployed by Security Officers as a last resort in a situation involving an immediate physical threat to safety. The new policy states "use of	3/28/16

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A 144	Continued From page 6 fractured arm for Patient #1 and placed all vulnerable patients at risk for SERIOUS INJURY resulting in IMMEDIATE JEOPARDY. Additionally, the hospital's failure to respond with appropriate interventions to secure a safe setting for provision of care demonstrates the IMMEDIATE THREAT TO THE HEALTH AND SAFETY of patients is ongoing. The findings included: 1. Review of the facility's policy "Security Management Plan" reviewed 1/2011 and 5/2015, effective date 1/1997, and revised 5/2012 and 2/2013 revealed, "[Hospital name] exists to benefit the people of our region by promoting good health, and by healing, caring and comforting... [Hospital] maintains a security management program that is designed to provide a safe and secure physical environment free of hazards and risks for patients... The purpose of the Security Management Plan is to define the program to minimize the risk of injury or property loss involving patients, visitors... Training hospital Associates is critical to their performance. Associates are trained to recognize and report either potential or actual incidents to ensure a timely response. Associates in security-sensitive areas are familiarized with the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors..." 2. Review of the EMS report dated 12/23/15 revealed EMS arrived on the scene at 1:46 AM to find a 57 year old male sitting in the yard. "...The pt [patient] mother stated that the pt started drinking alcohol and had too much. The pt was responsive to verbal stimuli only..." The patient	A 144	Continued From page 6 weapons and security handcuffs is considered a law enforcement activity, not a healthcare intervention," and the perpetrator who is demonstrating criminal activity should be turned over to law enforcement. The policy further clarifies that "weapons or handcuffs should not be used to subdue a patient to apply a health care restraint/seclusion." (See Appendix C - Policy and Approvals) **Associate Training and Competencies:** By 3/30/16, all Security Officers received training on the new Policy and a competency test was required for all Security Officers who had previously completed the training. Security Officers who scored below 90% on the competency test were required to complete the full 2-day Basic Officer Training by 3/18/16, which was taught by certified trainers. Additionally all Security Officers in the system who did not have the appropriate documentation of training on file completed non-violent and crisis intervention (CPI) and Basic Officer Training by 3/18/16, which was taught by certified instructors. Initial (new hire) and ongoing (annual) training and competency expectations were developed and approved by the Task Committee on 3/11/16. The Security Directors and system Director for Safety, Emergency Management and Security will ensure initial competencies are completed within 30-days of hire (and prior to issuing equipment) and ongoing competencies are completed annually.	3/30/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 144	Continued From page 7 was transported to the hospital. The EMS report documented the patient's vital signs were within normal limits and blood glucose level was 90. The patient received 300 milliliters of normal saline en-route to the hospital. 3. Medical record review for Patient #1 revealed the patient was a 57 year old male who arrived at the hospital's ED by EMS on 12/23/15 at 3:20 AM. The ED notes documented, "[Patient #1] passed out after drinking too many Busch beers. 'my dad died yesterday and I have a lot going on'..." 4. Review of the ED Nursing notes dated 12/23/15 revealed the following: 3:20 AM- ED Triage Assessment form documented the patient's visit reason as Intoxicated. 3:25 AM - Registered Nurse (RN) #2 documented labs were drawn. Results of the blood alcohol level were 374 milligrams per deciliter (mg/dl). The reference range (the range negative for alcohol) used by the laboratory was < = 3 (less than or equal to 3). 3:59 AM - RN #2's assessment completed. There was no documentation the patient was exhibiting inappropriate behaviors. 7:05 AM - Care of the patient was transferred to the day shift nurse, RN #1. There was no documentation from 3:59 AM to 7:05 AM that the patient was exhibiting inappropriate behaviors. 7:15 AM - RN #1 documented "pt removed own int [intermittent access]. dressing applied. pt agitated yelling out. spoke with pt in the attempts to calm down. pt somewhat better at this time." 7:45 AM - "pt refusing additional int. [Physician #1] notified. Awaiting orders" 7:55 AM - "[Physician #1] at bs [bedside]."	A 144	Continued From page 7 Security Officer training and competencies are provided initially upon hire and annually to reinforce the appropriateness of basic officer skills, nonviolent crisis intervention (CPI) de-escalation techniques, all to address the management and safety of patients in our hospital facilities. Compliance with the training will be monitored by the system Director of Safety, Emergency Management and Security and Security Directors, and evidence of completion will be documented in Department/Human Resource files by 3/30/16. **Compliance Monitoring:** The new System Director of Safety, Emergency Management and Security will have oversight of the QAPI program for the Security Department and will ensure that each physical intervention event is entered by the Security Officers, or designee, into the hospital's electronic incident reporting system (Safeguard) and reviewed independently by two Security Directors from another hospital site to determine appropriateness of the de-escalation and the level of physical intervention. The new system Director of Safety, Emergency Management and Security will ensure that the independent review is reported by the Security Directors in the Environment of Care - Security Subcommittee, monthly. Additionally each event with harm will be reported to the CEO, or designee, by the next	3/30/16

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A 144	Continued From page 8 8:00 AM - "pt out of rm [room]. Remains slightly agitated at this time. Pt informed to return to bed. Pt slow to comply." 8:45 AM - "pt continues to yell off and on. pt verbal with staff. pt informed to calm down." 9:00 AM - "pt argumentative with staff standing in doorway. Security called. pt placed back in bed and was informed to stay in bed until [Physician #1] notified." 9:05 AM - "pt standing outside of doorway, aggitated [agitated]/arguementative [argumentative] with staff. Mother at bs at this time. pt informed to go back to room as it is unsafe in hallway. pt refused. pt yelling derrogatory [derogatory] remarks to staff. Security called back to room." 9:15 AM - "[Name of Security Officer #1], security at bs. pt yelling at staff/now clinging to door handle. [Name of Security Officer #1] grasping L [left] wrist to control pt. pt began to push [Name of Security Officer #1] away and swung L arm around. [Name of Security Officer #1] requested pt to stop acting this way. pt noncompliant at this time. pt continues with foul language now directed at [Name of Security Officer #1]. [Name of Security Officer #1] pulled on pt L wrist to assist pt back to bed. pt kicked leg up with possible attempt to kick [Name of Security Officer #1] or to lock foot around door. Heard a loud 'pop'. pt yelled out. 'you broke my arm you MF!" Mother ran to pt to calm him down. Pt placed in we [wheelchair]. I exited rm [room] to inform [Physician #1]. " 9:19 AM - "[Physician #1] at bs for eval [evaluation]. Security remains at bs." 9:25 AM - "pt transport to xray per we [wheelchair] per edt [emergency department technician] with security escort (Security Officer #18)."	A 144	Continued From page 8: weekly business day, and a comprehensive and thorough causal analysis will be completed by the system Director of Safety, Emergency Management and Security, Security Directors, and Director of Risk Management within 45-days of the event to identify opportunities for improvement. Evidence of the causal analysis will be on file in the Risk Management Department and in the minutes of the Environment of Care Security Subcommittee meetings, monthly. The physical intervention events will be reported monthly to the appropriate hospital site and system QAPI committees and the Board Quality Committee. The system Director Safety, Emergency Management and Security will ensure information is appropriately documented in related QAPI committee minutes in the required frequencies. Additionally, the system Director of Safety, Emergency Management and Security, and/or designee, will randomly audit 10 Security Officer files to ensure training and competencies are complete, monthly for 24-months.	

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A 144	Continued From page 9 9:30 AM - "spoke with [name], mother of pt. r/t [related to] poc [plan of care]. Verbalized understanding." 9:33 AM - "pt returned from xray. In speaking with pt. pt remains mildly agitated, however is calm enough to have an intelligent conversation. pt somewhat apologetic at this time." 9:55 AM - "...pt medicated with Tylenol 650 mg po." 10:00 AM - "...int to RAC [right antecubital]...no status change. will continue to monitor." 10:30 AM - "pt with continue pain. [Physician #1] notified. Orders received and completed." 10:35 AM - "splint/sling to L arm. pt tolerated procedure well." 11:52 AM - pt was discharged home with his mother. 5. Review of ED Provider Notes dated 12/23/15 revealed the following documentation by Physician #1: 7:55 AM - "... Chief Complaint from Nursing Triage Note: 12/23/15 3:20 AM ... passed out after drinking too many Busch beers. 'my dad died yesterday and I have a lot going on'. The patient presents with alcohol intoxication. The onset was unknown... Pt states that his father just died yesterday. Usually drinks two beers daily but today he thinks he drank about six beers. Doesn't remember much after that, just remembers waking up in the emergency room. States he does not know what he's doing here... Laboratory results... Serum Ethyl Alcohol 374 milligrams per deciliter (mg/dl) CRIT [critical value] ... " 9:11 AM - "called to room - pts mother is now here and is able to take him home. Pt is belligerent right now, arguing and cursing. Security guard is present. Trying to calm situation at this point. Pt is medically cleared for discharge	A 144		

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A 144	Continued From page 10 home now that his mother is here and can take him home (preveious plan was behavioral health for drunk tank as he had been unable to get a ride before)" 9:16 AM - "Called to room again. Pt complaining of left forearm pain. Per report of security guard and nurse present at this time, patient (who remains intoxicated and is currently very belligerent) was holding onto the door with one arm and trying to kick the security guard. The security guard took hold of his left arm to try to hold him off and a pop was heard, then pt c/o [complained] pain. Will xray forearm now." 9:45 AM - "xray has been completed and film reviewed (final read pending)- ulnar shaft fracture noted, ortho [orthopedics] paged for consult, awaiting callback." 10:15 AM - "Arm rechecked... distal mobility and sensation intact. Mild swelling... No gross deformity..." Physician #1 ordered the following: Norco (hydrocodone bitartrate) 7.5 mg-325 mg tablet now and apply Left arm Posterior splint. "Discussed results w patient including ortho recs. Posterior splint to be placed, then ok to de home with mother to *flu* w ortho outpatient. Patient advised against alcohol abuse... Diagnosis: Acute alcohol intoxication, Left ulnar fracture... Condition: Stable Disposition: Medically cleared, Discharged... home. Patient was given the following educational materials: ALCOHOL INTOXICATION, ALCOHOL ABUSE, FRACTURE, Upper Extremity. Follow up with Physician #2 within 5 to 7 days... Discharge patient... Home, with mother after splint placement..." 6. Review of the x-ray report dated 12/23/15 at 9:18 AM revealed, "Clinical Information: Left arm pain, fracture...There is an oblique comminuted	A 144		

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A 144	Continued From page 11 [shattered] fractures of the distal shaft of the ulna. The radius appears to be intact" 7. Review of the facility video (no audio recording) of the ED for 12/23/15 beginning 9:03 AM revealed Patient #1 standing in the hallway in front of his room in the ED talking. At 9:05 AM, Patient #1 is assisted into the room by Registered Nurse (RN) #1 with Security Officer #1 present RN #1 and Security Officer #1 assist Patient #1 into his ED room on different occasions. At 9:13 AM Patient #1's mother arrived at the doorway of Patient #1's room. She is observed in the hallway with RN #1. At 9:14 AM Patient #1 and his mother are standing in front of the patient's room. The mother is observed shaking her finger at Patient #1. Patient #1 and his mother, Security Officer #1 and RN #1 are observed to enter the patient's room. At 9:15 AM Physician #1 is observed talking to the patient's mother. At 9:16 AM, Security Officer #1 is observed outside of the patient room attempting to close the door but unable to do so. Security Officer #1 turns around to see why the door will not close. Security Guard #1 entered the patient's room, followed by RN #1. The RN came out of the patient's room, and returned with the physician. 8. During an interview in the conference room of North campus on 2/24/16 at 9:25 AM, RN #1 stated Patient #1 was "...belligerent, yelling, cussing... whole 9 yards... called [Security Officer #1] trying to get him to calm down, [Patient #1 became] more angered... [Security Officer #1] grabbed him [Patient #1], heard 'pop'..." During a telephone interview on 2/25/16 at 8:06 AM, Patient #1 stated he told the Security Officer #1 he was leaving, and Security Officer #1 told	A 144		

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A 144	Continued From page 12 him he was not leaving. The patient stated he put his foot in the door. He stated Security Officer #1 walked over to him, grabbed his arm and snapped it. The patient stated he called Security Officer #1 "...Mr. Clean, I guess he didn't like that. He was a tall, bald guy in a white shirt... Guess I shouldn't have said it... my father had passed away December 21st..." The patient stated the x-ray showed his arm was broken. During a telephone interview on 2/25/16 at 8:40 AM, Security Officer #1 stated, "I was assaulted by this patient. He hit me, punched me, kicked me ... this patient was out of control. He was combative. They called for Security and I responded... He assaulted me... he accidentally got his arm broke..." There was no documentation in the medical record Security Officer #1 had been hit, punched or kicked. The Security Officer Supervisor provided the surveyor with a list of security staff and the date of the most recent department specific training the officers attended. There was no documentation of continuing education on department specific security issues for security officers between October 2014 and January 2016.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on policy review, medical record review, video recording review and interview, the hospital	A 145	Actions to Protect Patients' Rights: Immediately upon completion of the exit conference on 3/1/16 and receipt of the CMS 2567 on 3/8/16, action was taken to confirm the hospital continues to provide care in a safe setting, including –	3/28/16

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A 145	Continued From page 13 staff failed to adhere to policies to ensure vulnerable patients were protected at all times and their rights, dignity and well-being were preserved for 1 of 1 (Patient #1) sampled patients whose right to be free from abuse was violated. Failure of follow policies and procedures, protect patients from abuse and to treat patients with dignity and respect resulted in Patient #1 sustaining a fracture of the arm from inappropriately applied restraining measures and placed all vulnerable patients at risk for SERIOUS INJURY resulting in IMMEDIATE JEOPARDY. Additionally, the hospital's failure to respond with appropriate interventions to ensure patients are safe from abuse demonstrates the IMMEDIATE THREAT TO THE HEALTH AND SAFETY of patients is ongoing The findings included: 1. Review of the facility's policy "Security Management Plan" reviewed 1/2011 and 5/2015, effective date 1/1997, and revised 5/2012 and 2/2013 revealed, "[Hospital name] exists to benefit the people of our region by promoting good health, and by healing, caring and comforting... [Hospital] maintains a security management program that is designed to provide a safe and secure physical environment free of hazards and risks for patients... The purpose of the Security Management Plan is to define the program to minimize the risk of injury or property loss involving patients, visitors... Training hospital Associates is critical to their performance. Associates are trained to recognize and report either potential or actual incidents to ensure a timely response. Associates in security-sensitive areas are familiarized with the protective measures designed for those areas and their	A 145	Continue From page 13 1) Task Committee convened on 3/2/16; 2) Security Officers without evidence of proper training no longer provided equipment effective 0800 3/2/16; 3) Immediate training and competency test for Security officers competed by 3/10/16; 4) Board of Directors was notified and confirmation of their role in oversight by 3/10/16; 5) Facility CEOs notified and their role in oversight and management of the Security Department confirmed by 3/28/16; 6) Use of physical intervention and CPI training completed by all Security Officers by 3/18/16; 7) Initial and ongoing competencies for Security Officers developed and approved by 3/11/16; and 8) Enhanced QAPI program for Security physical intervention occurrences and patient safety confirmed and continuously in place by 3/18/16. **Policy Review and Revision:** The Task Committee and the CEO reviewed, revised and approved the Security Policy: Use of Security Personnel to Deescalate and Resolve Threats to Safety on 3/28/16. The Policy ensures that crisis intervention and de-escalation techniques are used as the initial response and weapons are only deployed by Security Officers as a last resort in a situation involving an immediate physical threat to	3/28/16

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A 145	Continued From page 14 responsibilities to assist in protection of patients, visitors... The following areas are currently designated as sensitive areas based on historical precedence, internal assessments, patient information (HIPPA), or a high level of security from government and other regulations or standards... Emergency Department [ED] - high level of transient traffic... Personnel are reminded during their annual education about those areas of the facility that have been designated as security-sensitive. Associates assigned to work in sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area... All Associates are required to complete annual training... Department Directors are responsible for orientating Associates upon initial hire, and annually on department specific security issue..." 2. Medical record review for Patient #1 revealed the patient was a 57 year old male who arrived at the hospital's ED by Emergency Medical Services (EMS) on 12/23/15 at 3:20 AM after passing out in a family member's yard. The ED notes documented, "[Patient #1] passed out after drinking too many Busch beers. 'my dad died yesterday and I have a lot going on'..." The ED Triage Assessment form documented the reason for ED visit as Intoxicated. A blood alcohol level was drawn and the results were 374 (reference range used by this facility is less than or equal to 3 as being negative for alcohol). At 9:00 AM the nursing notes documented " pt argumentative with staff standing in doorway. Security called. pt placed back in bed and was informed to stay in bed until [Physician #1] notified." At 9:15 AM the nursing notes documented	A 145	Continued From Page 14 safety. The new policy states "use of weapons and security handcuffs is considered a law enforcement activity, not a healthcare intervention," and the perpetrator who is demonstrating criminal activity should be turned over to law enforcement. The policy further clarifies that "weapons or handcuffs should not be used to subdue a patient to apply a health care restraint/seclusion." (See Appendix C - Policy and Approvals) **Associate Training and Competencies:** By 3/30/16, all Security Officers received training on the new Policy and a competency test was required for all Security Officers who had previously completed the training. Security Officers who scored below 90% on the competency test were required to complete the full 2-day Basic Officer Training by 3/18/16, which was taught by certified trainers. Additionally all Security Officers in the system who did not have the appropriate documentation of training on file completed non-violent and crisis intervention (CPI) and Basic Officer Training by 3/18/16, which was taught by certified instructors. Initial (new hire) and ongoing (annual) training and competency expectations were developed and approved by the Task Committee on 3/11/16. The Security Directors and system Director for Safety, Emergency Management and Security will ensure initial competencies are completed within 30-days of hire (and prior to issuing equipment) and ongoing	3/30/16

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A 145	Continued From page 15 Security Officer #1 attempted to get the patient to return to the bed, grabbed the patients left wrist and a loud "pop" was heard. The patient yelled that his arm was broken. 3. Review of ED Provider Notes dated 12/23/15 at 9:11 AM revealed Physician #1 was "called to room - pts mother is now here and is able to take him home. Pt is belligerent right now, arguing and cursing. Security guard is present. Trying to calm situation at this point. Pt is medically cleared for discharge home now that his mother is here and can take him home (previous plan was behavioral health for drunk tank as he had been unable to get a ride before) " 4. Review of the facility video (no audio recording) of the ED for 12/23/15 beginning 9:03 AM revealed Patient #1 standing in the hallway in front of his room in the ED talking. At 9:05 AM, Patient #1 is assisted into the room by Registered Nurse (RN) #1 with Security Officer #1 present. RN #1 and Security Officer #1 assist Patient #1 into his ED room on different occasions. At 9:13 AM Patient #1's mother arrived at the doorway of Patient #1's room. She is observed in the hallway with RN #1. At 9:14 AM Patient #1 and his mother are standing in front of the patient's room. The mother is observed shaking her finger at Patient #1. Patient #1 and his mother, Security Officer #1 and RN #1 are observed to enter the patient's room. At 9:15 AM Physician #1 is observed talking to the patient's mother. At 9:16 AM, Security Officer #1 is observed outside of the patient room attempting to close the door but unable to do so. Security Officer #1 turns around to see why the door will not close. Security Guard #1 entered the patient's room, followed by RN #1. The RN came out of the patient's room, and	A 145	Continued From page 15 competencies are completed annually. Security Officer training and competencies are provided initially upon hire and annually to reinforce the appropriateness of basic officer skills, nonviolent crisis intervention (CPI) de-escalation techniques, all to address the management and safety of patients in our hospital facilities. Compliance with the training will be monitored by the system Director of Safety, Emergency Management and Security and Security Directors, and evidence of completion will be documented in Department/Human Resource files by 3/30/16. **Compliance Monitoring:** The new System Director of Safety, Emergency Management and Security will have oversight of the QAPI program for the Security Department and will ensure that each physical intervention event is entered by the Security Officers, or designee, into the hospital's electronic incident reporting system (Safeguard) and reviewed independently by two Security Directors from another hospital site to determine appropriateness of the de-escalation and the level of physical intervention. The system Director of Safety, Emergency Management and Security will ensure that the independent review is reported by the Security Directors in the Environment of Care - Security Subcommittee, monthly. Additionally any event with harm will be reported to the CEO, or designee, by the next weekly business day,	3/30/16

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A 145	Continued From page 16 returns with the physician. There was no observation on the video the patient was belligerent, combative, or exhibiting inappropriate behavioral activity. 5. Review of the clinical documentation dated 12/23/15 revealed Physician #1 was called to Patient #1's room at 9:16 AM, "...Pt complaining of left forearm pain. Per report of security guard and nurse present at this time, patient (who remains intoxicated and is currently very belligerent) was holding onto the door with one arm and trying to kick the security guard. The security guard took hold of his left arm to try to hold him off and a pop was heard, then pt c/o [complained] pain. Will xray forearm now." 6. Review of the x-ray report dated 12/23/15 at 9:18 AM revealed, "Clinical Information: Left arm pain, fracture ...There is an oblique comminuted [shattered] fractures of the distal shaft of the ulna. The radius appears to be intact." 7. Review of a list of the hospital's Security Department personnel revealed 17 Security Officers and a Supervisor were employed at the hospital. The Security Officer Supervisor provided the surveyor with a list of security staff and the date of the most recent department specific training the officers attended. There was no documentation of annual continuing education on department specific security issues for the following officers: Security Officer #1's date of hire was 4/17/16. There was no documentation of department level specific training. Security Officer #2's date of hire was 7/2/12. The last annual department level specific training was documented 1/2014. There was no	A 145	Continued From page 16 and a comprehensive and thorough causal analysis will be completed by the system Director of Safety, Emergency Management and Security, Security Directors, and Director of Risk Management within 45-days of the event to identify opportunities for improvement. Evidence of the causal analysis will be on file in the Risk Management Department and in the minutes of the Environment of Care Security Subcommittee meetings, monthly. The physical intervention events will be reported monthly to the appropriate hospital site and system QAPI committees and the Board Quality Committee. The System Director of Environmental Health and Safety will ensure information is appropriately documented in related QAPI committee minutes in the required frequencies. Additionally, the system Director of Safety, Emergency Management and Security, and/or designee, will randomly audit 10 Security Officer files to ensure training and competencies are complete, monthly for 24-months.	

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A 145	Continued From page 17 documentation of continuing education on an annual basis. Security Officer #3's date of hire was 11/11/13. The last department level specific training was documented 1/2014. There was no documentation of continuing education on an annual basis. Security Officer #4's date of hire was 9/15/14. The last department level specific training was documented 10/2014. There was no documentation of continuing education on an annual basis. Security Officer #5's date of hire was 12/19/90. The last department level specific training was documented 4/2012. There was no documentation of continuing education on an annual basis. Security Officer #6's date of hire was 6/18/12. The last department level specific training was documented 8/2012. There was no documentation of continuing education on an annual basis. Security Officer #9's date of hire was 10/22/01. The last department level specific training was documented 5/2012. There was no documentation of continuing education on an annual basis. Security Officer #10's date of hire was 12/06/10. The last department level specific training was documented 12/2010. There was no documentation of continuing education on an annual basis. Security Officer #12 s date of hire was 8/8/82. The last department level specific training was documented 12/2010. There was no documentation of continuing education on an annual basis. Security Officer #15's date of hire was 9/28/15. There was no documentation of department level	A 145		

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A 145	Continued From page 18	A 145		

specific training.
Security Officer #16's date of hire was 8/2/10. The last department level specific training was documented 1/2014. There was no documentation of continuing education on an annual basis.
Security Officer #17's date of hire was 6/4/12. The last department level specific training was documented 7/2013. There was no documentation of continuing education on an annual basis.

8. During an interview on 2/24/16 at 9:50 AM in the hospital's classroom, the Security Officer Supervisor stated security officers were trained in, "...de-escalation, use of force, tactics, and checked-off for aerosol and baton..."

During an interview on 2/24/16 at 10:30 AM in the classroom, the Security Officer Supervisor stated the officers received training yearly to review paper work and maneuvers. The Security Officer Supervisor was asked if he had any documentation of staff attending the yearly reviews. The Security officer Supervisor stated he did not have documentation of this training. The surveyor asked if Human Resources kept a copy of Security Officer training and he stated no, that was kept by the Security Department. When the surveyor asked the Security Officer Supervisor about the incident between Patient #1 and Security Officer #1, he stated he had no behavior problems with Security Officer #1.

During a telephone interview on 2/25/16 at 8:40 AM when Security officer #1 was asked what his job responsibilities were he stated, "...Iwas supervisor of security... had numerous duties... taught CPI (Crisis Prevention Intervention)

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A 145	Continued From page 19 classes... self-defense instructor... last class taught was November or December 2015... " When the surveyor asked Security Officer #1 what happened during his interaction with Patient #1, he stated the patient "was out of control. He was combative... He assaulted me ... he accidently got his arm broke..." 9. Review of an email dated 2/25/16 from the Chief Operating Officer (COO) to the surveyor revealed "...Prior to... [December 2015] the only Security specific training required for our officers was the basic baton and basic aerosol training..."	A 145		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on facility policy review, document review and interview, the facility failed to ensure it maintained an effective and on-going Quality Assessment and Performance Improvement	A 263	QAPI: **Program Review:** On 3/11/16, The Task Committee discussed and confirmed the enhanced QAPI program for the Security Departments' physical intervention events. The new system Director of Safety, Emergency Management and Security will have responsibility to ensure this program is adhered to by all hospital sites and that data, event review, causal analysis, shared learning, and reporting is completed timely and shared throughout the system. This QAPI program has the following components: 1) Reporting of physical intervention events in the hospital's electronic system (Safeguard) by the Security Officer, or designee; 2) Reporting of all physical intervention events resulting in harm to the CEO by next weekly business day; 3) Independent review of all physical intervention events by two Security Directors from another hospital site to determine if the	3/30/16

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A 263	Continued From page 20 (QAPI) program to prevent adverse patient events. The failure by the facility to provide appropriate and timely interventions to secure a safe setting for the provision of care and prevention of abuse placed all vulnerable patients at risk for SERIOUS INJURY resulting in IMMEDIATE JEOPARDY. The hospitals' continued failure to intervene with appropriate and timely interventions to secure a safe setting for the provision of care demonstrates the IMMEDIATE THREAT TO THE HEALTH AND SAFETY of patients is ongoing. The findings included: 1. The facility failed to ensure the QAPI committee implemented appropriate preventative actions to secure a safe environment and prevent abuse. Refer to A 0286	A 263	Continued From page 20 application of de-escalation techniques and level of physical intervention was appropriate; 4) A Security Officer involved in an inappropriate use of physical intervention will be suspended, pending investigation; and if employment continues, retrained within 30-days before reissuing equipment; 5) Root Cause Analysis to be conducted on all events resulting in harm within 45-days; 6) Reporting and trending of events and causal analysis to the hospitals' QAPI committee ; and 7) Reporting and trending of events, results of the independent review, causal analysis, shared learning and improvement to the appropriate system QAPI committees and the Board Quality Committee. (See Appendix C -	
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.	A 286	Serious Safety Event Reporting Policy) **Compliance Monitoring:** The new system Director of Safety, Emergency Management and Security will review Safeguard reports, and relevant hospital site and system QAPI committee minutes to measure the reporting of events, event review, causal analysis, and reporting to QAPI committees is completed thoroughly and timely. This review will take place monthly for at least 24-months, or until compliance is sustained at 90% for 6-months. (See Appendix E - Compliance Monitoring)	3/30/16

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A 286	Continued From page 21 (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on facility policy, facility document review, record review, observation and interview, the Quality Assessment and Performance Improvement (QAPI) committee failed to ensure an ongoing hospital-wide program that identified, fully analyzed and addressed all contributing factors related to adverse events resulting in 1 of 1 (Patient #1) experiencing a fractured arm. The failure of the QAPI committee to analyze the causes resulted in the facility's failure to implement corrective actions to ensure patient injury did not reoccur, resulted in a SERIOUS and IMMEDIATE THREAT to the health and safety of all patients and placed them in IMMEDIATE JEOPARDY and risk of serious injuries and/or death. The hospitals' continued failure to fully analyze and address factors with appropriate and timely interventions to secure a safe setting for the provision of care demonstrates the IMMEDIATE THREAT TO THE HEALTH AND SAFETY of patients is ongoing. The findings included:	A 286	Continued From page 21 Patient Safety: **Program Review:** On 3/11/16, The Task Committee discussed and confirmed the enhanced QAPI program for the Security Departments' physical intervention events. The new system Director of Safety, Emergency Management and Security will have responsibility to ensure this program is adhered to by all hospital sites and that data, event review, causal analysis, shared learning, and reporting is completed timely and shared throughout the system. This QAPI program has the following components: 1) Reporting and of physical intervention events in the hospital's electronic system (Safeguard) by the Security Officer, or designee; 2) Reporting of all physical intervention events resulting in harm to the CEO by next weekly business day; 3) Independent review of all physical intervention events by two Security Directors form another hospital site to determine if the application of de-escalation techniques and level of physical intervention was appropriate; 4) A Security Officer involved in an inappropriate use of physical intervention will be suspended, pending investigation; and if employment continues, retrained within 30-days before reissuing equipment; 5) Root Cause Analysis to be conducted on all events resulting in harm within 45-days; 6) Reporting and trending of physical harm	3/30/16

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A 286	Continued From page 22 1. Review of the facility policy, "Use of Force-Security" effective 8/3/09 documented, "...One common definition of reasonable force is simply not to be excessive, under the circumstances... Use of Force Continuum is broken down into six broad levels. Each level is designed to have an elastic factor as the need for force changes as the situation evolves. It is common for the level for force to go from level two to level three and back again in a matter of seconds. The force level should always be appropriate for the circumstances and adjust up and down as the situation requires... Level Two: ...The right combination of words in combination with officer presence can de-escalate a tense situation and prevent the need for a physical altercation. Training and experience improves the ability of a security officer to communicate effectively with everyone including the police... Level Three - Control Holds & Restraints. Certain situation may arise where words alone does not reduce the aggression. Sometimes security guards and security officers will need to get involved physically. At this level, minimal force would involve the use of bare hands to guide, hold and restrain... A baton can only be used at this level as a self-defense mechanism to block blows or temporarily restrain... Level Four - Chemical Agents. Sometimes when... violent or threatening, more extreme, but non-deadly measures must be used in defense to bring the suspect under control... Before moving to level four, it is assumed that other less physical measures had been tried or was deemed inappropriate. ... Even though considered non-deadly, chemical sprays can cause a severe reaction and even death... with medical or allergic conditions... Training is the Key- To fully understand the force continuum it must be	A 286	Continued From page 22 the hospitals' QAPI committee ; and 7) Reporting and trending of events, results of the independent review, causal analysis, shared learning and improvement to the appropriate system QAPI committees and the Board Quality Committee. (See Appendix C - Serious Safety Event Reporting Policy) **Compliance Monitoring:** The new system Director of Safety, Emergency Management and Security will review Safeguard reports, and relevant hospital site and system QAPI committee minutes to measure the reporting of events, event review, causal analysis, and reporting to QAPI committees is completed thoroughly and timely. This review will take place monthly for at least 24-months, or until compliance is sustained at 90% for 6-months. (See Appendix E - Compliance Monitoring)	3/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 286	Continued From page 23 periodically discussed and reviewed by security supervisors. Practical exercises will help re-enforce the training and cause the reactions to become more appropriate instead of instinctual. In a crisis situation, fear and adrenalin have a way of accelerating the force continuum. Practice and ongoing training exercises will ease the effects of stress and make the safe outcome more predictable..." 2. Review of the Safety Operations Committee meeting minutes for 1/14/16 documented a reportable adverse event of physical abuse on 3/21/15. The adverse event was, "inappropriate interaction by a Security Officer with a Emergency Room patient, use of the baton did not align with the policy and procedure". There was no other information regarding this adverse event. There was no documentation the committee had fully analyzed the root cause of the abuse by the security officer. The Action Plan to prevent the abuse from recurring was Crisis Prevention and Intervention (CPI) training and in-service which was to be completed by 5/5/15. There was no documentation the training and in-service had been completed by 5/15/15. The Safety Operations Committee meeting minutes for 1/14/16 documented a second reportable adverse event of physical abuse on 12/23/15. The event was documented as, "intoxicated ED patient became belligerent and Security Office assistance was requested; a hand wrist grab was used in attempt to control patient resulting in injury to patient. An x-ray revealed a comminuted fracture to the distal shaft of the ulna. The patient received immediate treatment and discharged home with Ortho [orthopedic]	A 286		

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A 286	Continued From page 24 follow-up". The Action Plans for the second adverse event were CPI and de-escalation training for the security department and ED Leadership. This was to be completed by 1/13/16. There was no documentation the CPI training and de-escalation training for the Security officers and ED leadership was completed by 1/13/16. There was no documentation QAPI had implemented measures to ensure the adverse events were corrected and would not re-occur prior to the surveyors visit on 2/22/16 for these two allegations of abuse. 3. Medical record review for Patient #1 revealed the patient arrived at the ED via ambulance on 12/23/15 at 3:20 AM after passing out in a family member's yard. A blood alcohol level was drawn and the results were 374 (reference range used by this facility is less than or equal to 3 as being negative for alcohol). There was no documentation from the time of the patient's arrival until 9:00 AM the patient was agitated. At 9:00 AM the nursing notes documented the patient became agitated, was argumentative with staff and a Security Officer was called to the ED. At 9:15 AM the nursing notes documented the Security Officer #1 attempted to get the patient to return to the bed, grabbed the patients left wrist and a loud "pop" was heard. The patient yelled that his arm was broken. An xray revealed the patient had sustained a fractured left arm. 4. Review of the hospital video footage (no audio recording) which recorded the hallway of the ED and the entrance to the patient's room on 12/23/15 beginning 9:03 AM revealed Patient #1 was standing in the hallway in front of his room.	A 286		

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A 286	Continued From page 25 The patient appeared to be talking. At 9:05 AM Patient #1 was assisted back inside his room by Registered Nurse (RN) #1 with Security Officer #1 present. The video showed RN #1 and Security Officer #1 assisting Patient #1 back into his ED room on several occasions. At 9:13 AM Patient #1's mother was observed in the entrance/doorway of Patient #1's room. The patient's mother appeared to be talking with RN #1. At 9:14 AM it appeared Patient #1 and his mother were talking. The mother was observed shaking her finger at Patient #1. Patient #1, the patient's mother, the Security Officer #1 and RN #1 were observed entering the patient's room. At 9:15 AM Physician #1 was observed talking to the patient's mother. At 9:16 AM Security Officer #1 was observed walking out of the patient's room into the hallway and attempting to close the door of the patient's room but unable. It appeared the patient's hand was holding the door preventing the door from closing. Security officer #1 re-entered the patient's room followed by RN #1. Within a few seconds RN #1 came out of the patient's room and returned immediately with Physician #1. There was no observation on the video recording footage the patient was experiencing behaviors. 5. The facility's investigation determined the cause of the incident was the security officer. The facility terminated Security Officer #1's employment. The Committee Action Plans were CPI and de-escalation training for the Security Officers and ED leadership to be completed by 1/13/16. There was no documentation the CPI training and de-escalation training for the Security officers and ED leadership was completed by	A 286		

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A 286	Continued From page 26 1/13/16. There was no documentation QAPI had implemented action plans/interventions to ensure security officers were trained in CPI and de-escalation training or conducted oversight to ensure the abuse did not recur ongoing. 6. Review of an email dated 2/25/16 from the Chief Operating Officer to this surveyor revealed "...Prior to... [December 2015] the only Security specific training required for our officers was the basic baton and basic aerosol training..." 7. Review of 2/25/16 at 5:55 PM email from the Chief Operating Officer to the surveyor revealed training cards for Security Officers #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17 and 18 for completed training and certification for basic baton training and basic aerosol training with no completion date. 8. Review of basic aerosol training materials provided by the hospital revealed the following facts about aerosols: The aerosols effect the eyes, face, respiratory system and skin pigmentation. The physical actions include rigid muscles, auditory exclusions, tunnel vision, basic fear, blindness and suffocation. Review of basic baton training materials provided by the hospital revealed the following about baton usage: The use of a baton works on the motor nerves. Motor nerve points regulate the neural impulses that control the movement of muscles. When these signals are interrupted, there is a high intensity of pain, motor dysfunction/temporary paralysis of a particular muscle group, a sympathetic flexing response of the opposite unaffected joint.	A 286		

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A 286	Continued From page 27 9. Review of a list of Security Department personnel reviewed by the surveyor on 2/24/16 revealed there were 17 Security Officers and a Supervisor. The Security Officer Supervisor provided the surveyor with a list of staff and the date of the most recent department specific training the officers attended. There was no documentation of annual continuing education on department specific security issues for the following officers: Security Officer #1's date of hire was 4/17/16. There was no documentation of department level specific training. Security Officer #2's date of hire was 7/2/12. The last annual department level specific training was documented 1/2014. There was no documentation of continuing education on an annual basis. Security Officer #3's date of hire was 11/11/13. The last department level specific training was documented 1/2014. There was no documentation of continuing education on an annual basis. Security Officer #4's date of hire was 9/15/14. The last department level specific training was documented 10/2014. There was no documentation of continuing education on an annual basis. Security Officer #5's date of hire was 12/19/90. The last department level specific training was documented 4/2012. There was no documentation of continuing education on an annual basis. Security Officer #6's date of hire was 6/18/12. The last department level specific training was documented 8/2012. There was no documentation of continuing education on an	A 286		

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A 286	Continued From page 28 annual basis. Security Officer #9's date of hire was 10/22/01. The last department level specific training was documented 5/2012. There was no documentation of continuing education on an annual basis. Security Officer #10's date of hire was 12/06/10. The last department level specific training was documented 12/2010. There was no documentation of continuing education on an annual basis. Security Officer #12's date of hire was 8/8/82. The last department level specific training was documented 12/2010. There was no documentation of continuing education on an annual basis. Security Officer #15's date of hire was 9/28/15. There was no documentation of department level specific training. Security Officer #16's date of hire was 8/2/10. The last department level specific training was documented 1/2014. There was no documentation of continuing education on an annual basis. Security Officer #17's date of hire was 6/4/12. The last department level specific training was documented 7/2013. There was no documentation of continuing education on an annual basis. 10. During an interview on 2/22/16 at 11:30 AM in the Administrative conference room when questioned by the surveyor about the technique Security officer #1 had used on Patient #1 the Risk Manager from a satellite hospital campus stated, "...[name of Security Officer #1) was from the prison system... used a hold that was approved in prison... If person doesn't fight or	A 286		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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A 286	Continued From page 29 push against you, then no problem... Pushing against person causes torsion of bone..." 11. During an interview on 2/24/16 at 9:50 AM in the hospital classroom the Security Officer Supervisor stated Security Officer #1 had working experience in the penal system for 20 plus years as well as serving as a policeman in another State. 12. During an interview on 2/24/16 at 10:30 AM in the hospital classroom the Security Officer Supervisor stated the Security officers received training yearly to review paperwork and maneuvers. He stated the facility began using CPI training in 2010. The Security Officer Supervisor was asked if he had any documentation of staff attending the annual training reviews. The Security officer Supervisor stated there was no documentation of the annual review training. 13. There was no documentation the QAPI committee analyzed mitigating factors which created the potential for patient abuse and, implement preventive and corrective action plans that were developed by the committee. The committee continued to allow the use of batons by Security Officers providing them with the baton and aerosol training although it had been identified the Security officers had failed to follow hospital policies and procedures for the use of force. Refer to A 115, A 144, A 145	A 286		

Methodist Healthcare

SEP 8'17 AM10:16

September 7, 2017

Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Methodist Le Bonheur Healthcare, centered in Shelby County, is one of Tennessee's largest healthcare providers. Methodist Healthcare's principal acute care subsidiary organization is Methodist Healthcare--Memphis Hospitals that owns and operates five Shelby County hospitals. Methodist North Hospital is the 246-bed adult facility located in the northern quadrant of the Methodist service area. Methodist North is filing a Certificate of Need for the relocation of the 34-bed Methodist Psych inpatient unit currently located on the Methodist University Hospital campus to the Methodist North campus. As a result of extensive renovation and modernization plans approved by CN1602-009 for Methodist University, the building currently housing the Psych unit is scheduled to be demolished in 2019. Methodist North is the optimal location for the relocated service and beds.

Enclosed in triplicate is the corrected Letter of Intent for this project. The corrected Publication of Intent for this project will be filed in the Commercial Appeal on September 10, 2017. The anticipated filing date for the application is September 15, 2017. Please let us know if you have any questions or need additional information.

Sincerely,

Carol Weidenhoffer

Carol Weidenhoffer
Senior Director of Planning and Business Development

cc: Byron Trauger

SEP 8'17 AM10:15

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general circulation in Shelby County, Tennessee, on or before September 8, 2017 for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Methodist Healthcare - Memphis Hospitals dba Methodist North Hospital (a general hospital), owned and managed by Methodist Healthcare - Memphis Hospitals (a not for profit corporation), intends to file an application for a Certificate of Need for the relocation of 34 licensed adult psychiatric beds. The beds are currently located at 1265 Union Avenue, Memphis, TN 38104 on the Methodist University Hospital campus. Methodist Healthcare – Memphis Hospitals proposes to move them to 3960 New Covington Pike, Memphis, TN 38128 on the Methodist North Hospital campus. Both hospitals are operated under the Methodist Healthcare - Memphis Hospitals license and total licensed beds for the System will not change. There will be renovation of 18,976 square feet of space to accommodate the relocated psychiatric beds and services. The project does not contain any major medical equipment or initiate or discontinue any health service; and it will not affect any other licensed bed complements. The estimated project cost is $2,295,000

The anticipated date of filing the application is on or before September 15, 2017. The contact person for this project is Carol Weidenhoffer, Senior Director of Planning and Business Development, who may be reached at: Methodist Le Bonheur Healthcare, 1211 Union Avenue, Suite 865, Memphis, TN, 38104, 901-516-0679.

Carol Weidenhoffer (Signature) | 9/7/17 (Date) | carol.weidenhoffer@mlh.org (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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HF51 (Revised 01/09/2013 – all forms prior to this date are obsolete)

RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(Rule 0720-11-.01, continued)

(3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

(i) Those having the same accrediting standards as the licensed hospital of which it will be a department, for a Freestanding Emergency Department;

(ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects;

(iii) Commission on Accreditation of Rehabilitation Facilities (CARF), for Comprehensive Inpatient Rehabilitation Services and Inpatient Psychiatric projects;

(iv) American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority, for Megavoltage Radiation Therapy projects;

(v) American College of Radiology, for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects;

(Rule 0720-11-.01, continued)

(vi) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, or another accrediting body with deeming authority for hospice services from CMS or state licensing survey, and/or other third party quality oversight organization, for Hospice projects;

(vii) Behavioral Health Care accreditation by the Joint Commission for Nonresidential Substitution Based Treatment Center, for Opiate Addiction projects;

(viii) American Society of Transplantation or Scientific Registry of Transplant Recipients, for Organ Transplant projects;

(ix) Joint Commission or another appropriate accrediting authority recognized by CMS, or other nationally recognized accrediting organization, for a Cardiac Catheterization project that is not required by law to be licensed by the Department of Health;

(x) Participation in the National Cardiovascular Data Registry, for any Cardiac Catheterization project;

(xi) Participation in the National Burn Repository, for Burn Unit projects;

(xii) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives, Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects; and

(xiii) Participation in the National Palliative Care Registry, for Hospice projects.

(h) For Ambulatory Surgical Treatment Center projects, whether the applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

(i) For Cardiac Catheterization projects:

1. Whether the applicant has documented a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies;

2. Whether the applicant has agreed to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation; and

3. Whether the applicant will staff and maintain at least one cardiologist who has performed 75 cases annually averaged over the previous 5 years (for an adult program), and 50 cases annually averaged over the previous 5 years (for a pediatric program).

(j) For Open Heart projects:

1. Whether the applicant will staff with the number of cardiac surgeons who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and whether the applicant will maintain this volume in the future;

2. Whether the applicant will staff and maintain at least one surgeon with 5 years of experience;

3. Whether the applicant will participate in a data reporting, quality improvement, outcome monitoring, and peer review system that benchmarks outcomes based on national norms, with such a system providing for peer review among professionals practicing in facilities and programs other than the applicant hospital (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard);

(k) For Comprehensive Inpatient Rehabilitation Services projects, whether the applicant will have a board-certified physiatrist on staff (preferred);

(l) For Home Health projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(m) For Hospice projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(n) For Megavoltage Radiation Therapy projects, whether the applicant has demonstrated that it will meet the staffing and quality assurance requirements of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority;

(o) For Neonatal Intensive Care Unit projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; whether the applicant has documented the intention and ability to comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and whether the applicant will participate in the Tennessee Initiative for Perinatal Quality Care (TIPQC);

(p) For Nursing Home projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program. As an alternative to the provision of third party accreditation information, applicants may provide information on any other state, federal, or national quality improvement initiatives;

(q) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all

times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; and

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

(r) For Freestanding Emergency Department projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan;

(s) For Organ Transplant projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan; and

(t) For Relocation and/or Replacement of Health Care Institution projects:

1. For hospital projects, Acute Care Bed Need Services measures are applicable; and

2. For all other healthcare institutions, applicable facility and/or service specific measures are applicable.

(u) For every CON issued on or after the effective date of this rule, reporting shall be made to the Health Services and Development Agency each year on the anniversary date of implementation of the CON, on forms prescribed by the Agency. Such reporting shall include an assessment of each applicable volume and quality standard and shall include results of any surveys or disciplinary actions by state licensing agencies, payors, CMS, and any self-assessment and external peer assessment processes in which the applicant participates or participated within the year, which are relevant to the health care institution or service authorized by the certificate of need. The existence and results of any remedial action, including any plan of correction, shall also be provided.

(v) HSDA will notify the applicant and any applicable licensing agency if any volume or quality measure has not been met.

(w) Within one month of notification the applicant must submit a corrective action plan and must report on the progress of the plan within one year of that submission.

(4) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition; and

(Rule 0720-11-.01, continued)

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers.

(5) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Quality of Health Care to be provided. The applicant should show the quality of health care to be provided will be served at least as well as the original site.

(d) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(6) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 68-11-1605, 68-11-1609, and 2016 Tenn. Pub. Acts Ch. 1043.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005. Emergency rule filed May 31, 2017; effective through November 27, 2017.*

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: November 30, 2017

APPLICANT: Methodist Healthcare Memphis
d/b/a Methodist Healthcare North Hospital
3660 New Covington Pike
Memphis, Tennessee 38128

CONTACT PERSON: Carol Weidenhoffer
1211 Union Avenue, Suite 865
Memphis, Tennessee 38104

COST: $2,295,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, Methodist Healthcare-Memphis Hospitals, d/b/a Methodist North Hospital seeks Certificate of Need (CON) approval for the relocation of 34 licensed adult psychiatric beds. The beds are currently located at 11265 Union Avenue, Memphis Tennessee 38104 on the campus of Methodist University Hospital. Methodist Healthcare proposes to move the 34 beds to 3960 New Covington Pike, Memphis, Tennessee 38128 on the campus of Methodist North Hospital. Both hospitals are operated under the same license and the total licensed beds for the system will not change.

There will be a renovation of 18,976 square feet of space to accommodate the relocated psychiatric beds and services. The project does not contain any major medical equipment or initiate or discontinue any health service; and it will not affect any other licensed bed compliments.

The applicant owner and licensee is Methodist Healthcare-Memphis Hospitals, a not-for-profit corporation that operates five Shelby County hospitals under a single license.

The total project cost is $2,295,000 and will be funded through cash reserves as documented in a letter from the Chief Financial Officer in Attachment C: Economic Feasibility B6.

This application has been placed on the Consent Calendar. Tenn. Code Ann. § 68-11-1608 Section (d) states the executive director of Health Services and Development Agency may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

NEED:
The applicant's primary service area for this project is Shelby County. The 2017 18 and older Shelby County population is 716,092, increasing to 732,769 in 2021, and increase of 2.3%.

Currently Methodist University Hospital is undergoing a modernization plan approved under

CN1602-009. A part of that project is the demolition of the Crews building where the psychiatric hospital beds are housed. This project is the proposed transfer of the psychiatric hospital beds within the Methodist System that will result in no net increase in the total beds in the county. Methodist has a single license for all five Shelby County hospitals, with a total bed compliment of 1,593 beds.

This project will increase the Methodist North licensed beds by 34 beds (10 private and 24 semi-private) from 246 to 280. At the same time, Methodist University Hospital will close 34 beds and its licensed beds will decrease from 617 to 583.

The project was originally planned for the Methodist University campus but it was determined that the Methodist North campus was the optimal location. The project will renovate almost 19,000 square feet of space-almost 3,000 more than is currently occupied-on the Methodist North campus. The proposed location is a separate building attached to the main hospital but contained as singular space with a separate entrance. The secured, controlled access makes it an improved setting for the Methodist psychiatric services to ensure privacy and security.

The service area contains other psychiatric inpatient facilities including Delta Medical Center, Crestwyn Behavioral Health Hospital, Lakeside Behavioral Health System, St. Francis Hospital-Park and Memphis Mental Health Institute.

The applicant projects occupancy of 54% in 2020 and 60% in 2021

TENNCARE/MEDICARE ACCESS:
The applicant participates in the Medicare and TennCare/Medicaid programs. The applicant contracts with TennCare MCOs AmeriGroup, United Healthcare Community Plan, BlueCare, and TennCare Select.

The applicant projects year one Medicare revenues of $10,367,781 or 96.6% of total revenues and TennCare revenues of $33,209 or 0.3% of total revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Cost Chart is located on page 29 of the application. The total project cost is $2,295,000.

Historical Data Chart: The Historical Data Chart for the total facility is located on page 31 of the application. The applicant reported 10,803, 10,688, and 10,068 discharges in 2014, 2015, and 2016, with net operating income of $12,343,000, $10,300,000, and $9,543,000

Projected Data Chart: The Projected Data Chart for the total facility is located on page 36. The applicant projects 10,400 and 10,438 discharges in years one and two with net operating income of $5,082,000 and $4,213,000 each year, respectively.

Projected Data Chart: The Projected Data Chart for the project only is located on page 38. The applicant projects 337 and 375 discharges in years one and two with net operating income of $700,000 and $736,000 each year, respectively.

Proposed Charge Schedule

	Previous Year	Current Year	Year One	Year Two	% Change
Gross Charge	26,552	27,460	31,853	33,127	21%
Average Deduction	15,081	14,974	19,181	20,430	36%
Average Net Charge	11,471	12,485	12,673	12,698	2%

Facility	CON	Project Year	Gross Oper Rev Per Discharge	Net Oper Rev Per Discharge
Methodist North	Proposed Project	2020	31,853	12,673
Crestwyn Behavioral	CN1310-040	2015	13,804	7,799
TriStar Maury Regional	CN1610-036	2018	36,831	8,266
Parkridge West	CN1611-039	2018	28,748	3,603

Proposed Staffing

Title	Proposed FTE
RN	10.0
Activity Coordinator	0.5
Mental Health Counselor	1.0
Mental Health Tech	8.0
Patient Care Coordinator	1.0
Case Manager	1.0
Security	4.2
Maintenance	2.2
Total	27.9

Project Payor Mix Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	10,367,781	96.6
TennCare/Medicaid	33,209	0.3
Commercial/Other Managed Care	20,529	0.2
Self-Pay		
Worker's Comp		
VA	312,992	2.9
Charity Care		
Total	10,734,510	100

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The Methodist Healthcare-Memphis Hospitals' licensee includes five hospitals: Methodist University, Methodist South, Methodist North Methodist Le Bonheur Germantown and Le Bonheur Children's.

Additionally, Methodist owns and operates Methodist Alliance Services, a comprehensive home care company, and a wide array of other ambulatory services such as urgent care centers and ambulatory surgery centers.

Methodist Healthcare lists numerous other alliances on page 44 of the application.

The project should have a positive impact on the Shelby County health care community.

Methodist Healthcare has clinical affiliation agreements with multiple colleges for nursing, rehabilitation, pharmacy, and other allied health professionals. Methodist University Hospital offers a site for clinical training. There are 1,400 students participating in these programs annually at Methodist Healthcare.

Methodist Hospital System is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by The Joint Commission.

QUALITY MEASURES:

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   N/A

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      Methodist University Hospital is undergoing a modernization plan approved by CN1602-009. A part of that project is the demolition of the Crews building where the psychiatric hospital beds are housed, forced the relocation of the program and beds, with the approval and plans for the University campus, there is not a renovation option where the beds are housed in the Crew wing.

      Methodist is committed to maintaining psychiatric inpatient services for the community, therefor, new locations were considered, the possibilities were narrowed to the Methodist North campus. This project was the most cost effective location and less disruptive option for relocation.

      The choice to relocate the 34 beds to a hospital within the same system, only 13.7 miles away, allows Methodist to serve the same community with the same resources. The full program including equipment, staff, and physicians will be relocated simultaneously.

The majority of the patients admitted are SPMI patients who are psychiatrically disabled adults with Medicare coverage. Projections show the composition of the population and mix of populations served will not change.

Utilization and Occupancy

	2014	**2015**	**2016**	**2020**	**2021**
Discharges	**441**	**388**	**370**	**337**	**375**
Days	**8467**	**7791**	**7336**	**6640**	**7388**
Average Daily Census	**23.20**	**21.35**	**20.04**	**18.19**	**20.24**
Occupancy Rate	**68%**	**63%**	**59%**	**54%**	**60%**

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

      N/A

CERTIFICATE OF NEED REVIEW
Memphis North Hospital
CN1709-029

Methodist Healthcare-Memphis Hospitals dba Methodist North Hospital
3960 New Covington Pike
Memphis, TN 38128

October 27, 2017

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has reviewed the application for a Certificate of Need (CON) submitted by Methodist Healthcare-Memphis (MH-M) Hospitals to relocate an existing 34-bed inpatient psychiatric unit from Methodist University Hospital to Methodist North Hospital. TDMHSAS is not conducting a formal analysis of this project since the project does not propose to add beds or change a currently licensed service beyond relocation within the same county and service area. This review is intended to confirm that applicant plans to maintain the quality, staffing patterns, and contribution to healthy lives currently provided under the existing license.

SCOPE OF PROJECT

Currently, Methodist University Hospital is undergoing a modernization plan approved under CN1602-009. The project proposed in CN1709-029 will relocate an existing 34-bed inpatient psychiatric unit from the Crews building on the campus of Methodist University Hospital at the corner of Union Avenue and Bellevue Boulevard to the campus of Methodist North Hospital, 3960 New Covington Pike, approximately 13 miles away. The proposed relocation structure is adjacent to the main Methodist Hospital North campus with access to support services (environmental services, security, and nutrition) but has a secured, separate entrance.

The applicant proposes to renovate almost 19,000 square feet of space, about 3,000 more than the unit currently occupies. The estimated project cost is $2,295,000 which includes $1,384,375 in construction costs and will be funded in cash by the parent company Methodist Le Bonheur Healthcare. If the request is approved in December 2017, construction is projected to be complete in June of 2019 with issuance of service in July of 2019.

The 34-bed psychiatric unit relocated to the Methodist North Hospital campus will continue to serve patients with serious and persistent mental illnesses, most of whom will be covered by Medicare. The unit does serve the indigent population and the TennCare population on a case by case basis. Intellectual disability is a rule-out for admission, but the unit will continue to serve emergency involuntary and non-emergency indefinite admissions. The unit will maintain current staffing (27.91 FTE positions) with 12-hour nursing shifts and the flex model based on current census typical of inpatient psychiatric units. No FTEs are added or lost. Methodist has been providing this service to Shelby County for over 40 years. Methodist Healthcare-Memphis Hospitals will maintain the unit's current CMS accreditation.

The proposed relocation would not significantly affect access to health care or the conditions to achieve optimal health. The new location is within the same service area (Shelby County) on New Covington Pike near the intersection with Austin Peay Highway about 3.25 miles from I-40 and 13 miles from the current location. The majority of patients served arrive by ambulance during crisis or as direct referrals from the Crisis Assessment Centers. The plan as described appears to be consistent with applicants stated intention to "serve the same community with the same resources" (Supplemental #1, Page 5).

CONCLUSIONS

- There continues to be a need for the 34-bed inpatient psychiatric unit operated by Methodist Healthcare-Memphis Hospitals in the Shelby County service area. The project involves remodeling an existing hospital space rather than new construction.
- The relocated unit would provide health care that meets appropriate quality standards in the same service area (Shelby County) as the unit at the current location.
- The applicant proposes to maintain the same staffing pattern and total FTEs following completion of the relocation.
- The relocated unit would seek the current unit's CMS accreditation.
- The proposed organizational structure, physical plant, staffing and service delivery model are entirely consistent with current standards.
- The proposed relocation will remain in the same service area and will not adversely affect access.

The Tennessee Department of Mental Health and Substance Abuse Services supports the approval of the application for a Certificate of Need for Methodist Healthcare-Memphis Hospitals to relocate a currently licensed 34-bed inpatient unit from the Methodist University Hospital at 1265 Union Avenue to Methodist North Hospital at 3960 New Covington Pike.

Jeff Feix, Ph.D.
Director, Office of Forensic and Juvenile Court Services
Division of Planning, Research and Forensics, TDMHSAS